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# DRUG CRISIS: TREATMENT AND PREVENTION

## HEARING

BEFORE THE

## COMMITTEE ON LABOR AND HUMAN RESOURCES

## UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

EXAMINING STATE AND LOCAL TREATMENT AND PREVENTION PROGRAMS RELATING TO THE DRUG CRISIS

AUGUST 3 AND OCTOBER 25, 1989

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# CONTENTS

## STATEMENTS

THURSDAY, AUGUST 3, 1989


| | Page |
|---|---|
| Kennedy, Hon. Edward M., prepared statement | 3 |
| Simon, Hon. Paul, prepared statement | 5 |
| Hatch, Hon. Orrin G., prepared statement | 7 |
| Lucas, John, director, Students Taking Action Not Drugs (STAND), Houston, TX, and Delvin Williams, president, Pros for Kids, Burlingame, CA | 8 |
| Prepared statement of Delvin Williams | 14 |
| Coats, Hon. Dan, prepared statement | 23 |
| Coye, Dr. Molly Joel, Public Health Commissioner, State of New Jersey, Trenton, NJ | 29 |
| Prepared statement | 32 |
| Hughes, Major Doug, director, Office of Substance Abuse Control for Dade County, Miami, FL, and David Hatcher, drug treatment specialist and probation officer, Topeka, KS | 41 |
| Prepared statement of David Hatcher | 46 |
| Jones, Shannon, student, Olney High School, Philadelphia, PA, accompanied by Ann Zembroski, program coordinator for a drug and alcohol abuse program, Philadelphia, PA, and Kemma McAdoo, student, Jeremiah Burke School, Dorchester, MA, accompanied by Marianne Lee, deputy director, Governor's Alliance Against Drugs | 56 |
| Shankman, Dr. Sidney, director, Second Genesis, Washington, DC and Thomas L. Freestone, board of supervisors, Phoenix, AZ | 63 |
| Prepared statements of: | |
| Dr. Shankman | 67 |
| Mr. Freestone (with addition copy) | 78 |


WEDNESDAY, OCTOBER 25, 1989


| | |
|---|---|
| Kennedy, Hon. Edward M., prepared statement | 107 |
| Hatch, Hon. Orrin G., prepared statement | 110 |
| Schuster, Dr. Charles R., director, National Institute on Drug Abuse, Bethesda, MD | 111 |
| Prepared statement | 115 |
| Coats, Hon. Dan, prepared opening statement | 146 |
| Durenberger, Hon. Dave, prepared statement | 150 |
| Bell, Peter, executive director, Institute on Black Chemical Abuse, Minneapolis, MN, and Milton "Pete" Shrader, student, T.C. Williams High School, Alexandria, VA, accompanied by his mother, Connie Pulliam | 152 |
| Prepared statement of Peter Bell | 156 |
| Des Jarlais, Dr. Don, director for AIDS Research and Evaluation, Narcotics and Drugs Research, Inc., New York, NY, and Reverend Reginald Williams, deputy director, Addicts Rehabilitation Center, New York, NY | 171 |
| Prepared statements of: | |
| Dr. Des Jarlais | 174 |
| Rev. Williams | 184 |
| American Psychological Association, prepared statement | 187 |

## ADDITIONAL MATERIAL

Questions and answers: Page

Responses of Dr. Des Jarlais to questions asked by Senator Hatch ..... 180
Responses of Dr. Schuster to questions asked by Senator Mikulski ..... 195
Responses of Dr. Schuster to questions asked by Senator Hatch ..... 197
Responses of Dr. Schuster to questions asked by Senator Durenberger..... 204

# DRUG CRISIS: TREATMENT AND PREVENTION

THURSDAY, AUGUST 3, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
*Washington, DC.*

The committee met, pursuant to notice, at 10:00 a.m., in room SD–430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Adams, Hatch, Kassebaum, and Coats.

## OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

I am going to put my full statement in the record. Just in establishing the thrust of this hearing, I will go through these charts very briefly.

These are pretty familiar to most of us on this committee. I am not sure that the Congress and the Senate understand what has been happening with the 1988 and 1989 funding. These are the funds that have been allocated in the area of law enforcement/interdiction, as compared to the funds for treatment and education. Even going into 1989 we saw a very significant disparity with 71 percent of resources spent on law enforcement and 29 percent on education and treatment, even though in the Omnibus Drug bill of last year the Congress indicated that it wanted a 50/50 split. We are still not there. I think the way the various allocations have been made to the Appropriations Committee is not there, either.

We are encouraged by what the chairman of the Appropriations Committee said the other evening, that they were going to make some adjustments in the fall, but we still have this kind of disparity in allocation of resources.

This chart shows the dramatic increase in the Federal funding for interdiction and law enforcement from 1986 to 1989, ($1.8 billion to $3.7 billion) as compared to the declining costs of the street price of cocaine. This illustrates that increased law enforcement is not enough.

This next chart shows that education does make a difference. With an increased understanding among high school seniors about the dangers of cocaine use there is a corresponding decline in current cocaine use amount high school seniors.

The next chart shows the sources of the Seattle Project, which deals with gateway drugs: alcohol, smoking, and marijuana use. Students exposed to an educational social development program

were much less likely to initiate early use of gateway drugs than similar controls.

This chart shows the Kansas City Program, again on gateway drugs. A community-based prevention program significantly reduced the use of cigarettes and alcohol among teenagers. We are very hopeful that Mr. Bennett's proposal will show some sensitivity to these kinds of phenomenon, because clearly use of gateway drugs are related to later serious substance addiction and abuse. Another chart from the Kansas City program shows the decline as a result of some of the prevention programs, this time for marijuana and cocaine use. So, these studies demonstrate that prevention can be helpful.

This next chart demonstrates the latest figures on high school seniors using illicit drugs within the last year. Thirty-nine percent of all high school seniors still used an illicit drug within the last year. Of course, it does not take into consideration the approximately 800,000 or 900,000 high school dropouts, and obviously the incidence in terms of those dropouts would be much, much higher.

This chart shows the drug treatment outcomes of 27,000 individuals. These are drug abusers who have been examined in the Drug Abuse Reporting Program. What we are always faced with is what is really the cure, and all of us understand the complexity in reaching the point where an individual who is a serious abuser is going to be completely free from substance abuse. There are indications that, after people have gone through some of the well-documented programs, we see declining criminal activity, declining drug use and increasing employment. To the extent that, as a society, this is an objective, we do see some impressive results.

And this is a further indication of the new studies that will be released in the fall from the North Carolina Research Triangle Institute, and this study was done with about 10,000 individuals. It does indicate that after treatment that there are some impressive results: significant decreases in the daily use of cocaine and other drugs.

The next chart shows that treatment also reduces crime.

With regards to treatment savings, for every dollar that is spent on treatment, there are tremendous savings in crime costs. For those that are involved in residential programs, the savings for $1 spent on treatment is $3.84, for methadone maintenance, $4.04, and for outpatient treatment $1.28. So, every dollar that is invested in terms of prevention has a real impact in reducing crime in our community.

The last chart shows the number of prisoners in need of treatment and the percent who are actually receiving it. Only 11 percent of Federal and 20 percent of State prisoners who need treatment are receiving it. I think in the allocations of priorities, most people would say, well, let's treat the people outside the criminal justice system who want treatment. But obviously if we have effective programs—and there are some very impressive programs in treating prisoners—that has an important and significant effect in terms of violence in our society.

So, we are here today to hear from those that are not just statistics, but real life examples of individuals who have been working on this issue and from their own life experience can reveal to our

committee some of the impressive programs and individual examples that really add the body to these kinds of statistics. We are very grateful to all of those who have joined with us today.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. Today's hearing will focus on the social consequences of drugs and the need to increase our commitment to deal with the demand side of the problem by effective programs for education, prevention and treatment.

We will hear from professional athletes who have learned the dangers of drugs the hard way—and who now devote much of their time to persuading young persons not to follow that path. We will hear from youths who have grown up surrounded by drugs in their homes, their schools and their communities, and who are now working as peers to help their friends and neighbors escape the pervasive pressure of drugs.

The treatment crisis in America is a travesty of responsible policy. We cannot honestly say that we are working to solve the drug crisis if we have the capacity to treat less than one in six drug addicts seeking treatment. We will hear testimony from people on the front lines of the treatment battle, and who must say "no" every day to addicts crying out for help.

Supply side effects are important too. Interdiction and law enforcement must be vigorous components of any national anti-drug effort. The modern merchants of death must never get a free ride. It is a political fact of life that law enforcement and interdiction have an easier time obtaining funds. But we will never purge our society of drug addiction with a strategy that short changes prevention and treatment. Two law enforcement officials who have firsthand experience on the streets and in the prisons will tell us their perspective on the problem.

Well-designed prevention programs are cost-effective and have a track record of success. In the past 3 years, the number of students who believe that casual use of cocaine is harmful has increased by 51 percent. As a direct result of that shift in perception, the number of high school seniors using cocaine declined by 19 percent in 1987 and another 23 percent in 1988. The 1988 National Household Survey on Drug Use, released just this week, showed that between 1985 and 1988, the number of Americans who had used cocaine had declined by 33 percent.

But drug use in our country is still overwhelming. According to surveys, 39 percent of high school seniors, more than one million students, used an illegal drug last year. A quarter of a million used cocaine. Twenty-eight million Americans used some illegal drug at least once last year, and 8 million used cocaine.

Some local programs have achieved striking successes. The Kansas City school-community program showed a 46 percent decline in heavy marijuana use by junior high school students. In the Seattle program for elementary school students, fifth graders with 4 years in the program were 23 percent less likely to use "gateway" drugs like cigarettes and alcohol.

In spite of the demonstrable successes of this approach, the Federal commitment to school-based prevention through the Drug-Free Schools program in the Department of Education adds up to only a dollar per month per student.

The Office of Substance Abuse Prevention in the Department of Health and Human Services is getting twice as many approved applications for community-based prevention programs as it can fund. The same is true of the youth gangs program and the runaway and homeless youth program.

It is time to give these prevention programs the priority they need and the funding they deserve.

For millions of Americans, however, prevention is too late. According to the National Institute for Drug Abuse, 6.5 million citizens are deeply enough involved with drugs to require help to end their addiction.

Congress went on record in the 1988 Drug bill to achieve the goal of treatment on demand—but we are far from success.

Today we spend only enough to provide treatment to 15 percent of those who need it. Current backlogs cause unconscionable delays for thousands of citizens desperate to cure their addiction.

Treatment is effective. It reduces drug use dramatically, and the gains are maintained for as long as 12 years. Similar reductions are found in crime and unemployment. Based on savings from lower crime rates alone, treatment is cost-effective.

Even for cocaine addicts, who currently have no alternative like methadone for heroin, treatment reduces drug use substantially. It is also an essential means to stem the spread of AIDS among addicts and their sex partners.

Poll after poll demonstrates that the war on drugs is America's No. 1 domestic problem. But Congress after Congress refuses to provide the means to wage the war effectively. We know what works, and we can no longer accept the waste of lives and the long-term cost from our inaction. The war on drugs must be waged on all fronts, and that means prevention and treatment too.

Our hearing today will focus on the front-line of the drug war. It is a war we can and should win if we execute a realistic battle plan.

I recognize the Senator from the State of Washington.

Senator ADAMS. Thank you, Mr. Chairman.

I want to express my gratitude to you for holding these hearings. You and I discussed this some time ago when we first started action, not only on the drug bill but I am really here in a dual capacity, Mr. Chairman, as both the Chairman of the District of Columbia Subcommittee on Appropriations, where we are attempting to appropriate additional money for police, prosecutors, prison facilities. I have tried to emphasize that in this committee, of course, is the place where it should be done, that treatment is the only final and real solution for this problem.

I will be returning to my home State, Mr. Chairman, and in Seattle during the next few days. We will be going to see the so-called crack cocaine babies, which is one of the great crises and tragedies of what is occurring when we lack treatment and it is treatment that starts right at the cradle. The treatment at the cradle is necessary, because these babies are addicts at the time they are born.

I compliment you for holding this hearing and I am going to be looking forward to hearing from our witnesses. I just do not think there is any greater tragedy, Mr. Chairman, than our failure to win the war on drugs. We have to spend the money on it, both on first stopping the killing in the streets, which we intend to do when the District of Columbia bill comes up with appropriated money there, but, more importantly, the programs and the statistics that you are outlining here.

In the 100th Congress, I served with your colleague from the State of Massachusetts, Senator Kerry, on the interdiction portion of this, and I just want to state that the total overall problem also will involve the interdiction of cocaine and the change in what we are doing in terms of our use of all of our forces to stop the flow of drugs from Central America and from South America.

We found during those hearings—and you will remember that—that we really had a very difficult time. So, Mr. Chairman, I appreciate very much your hearing. We are going to do field work on this in the meantime, and you are certainly correct that this is the biggest problem in public health that we face in the United States.

The CHAIRMAN. We will just recess for about two minutes. I have a call.

Senator ADAMS. While the Chairman is recessed, Mr. Lucas, I want to welcome you here. I have been a great admirer of yours for many years, since you were first on the tennis circuit and then on the basketball circuit, and both from my home town and from here in the District, and we very much appreciate your being here with Mr. Williams to assist us with this.

I might state that we are particularly interested in your testimony and I have assigned a number of people to listen here today and be very attentive, because we will have the District of Columbia Appropriations bill up right after the recess and we want you to know that we intend to try to carry out some of the suggestions you will be making.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We will now receive a statement by Senator Simon.

[The prepared statement of Senator Simon follows:]

PREPARED STATEMENT OF SENATOR SIMON

Senator SIMON. I am pleased to join my distinguished colleagues of the Senate Labor and Human Resources Committee as we draw attention to the most pressing problem facing America today. The drug crisis in this country is of epidemic proportions. We must develop a common-sense approach for stepping up the Nation's war on illegal drugs.

The more you look at this problem, the clearer it is that the easy, dramatic answers will not work. We have to dig in and do the hard, undramatic things that count.

The *Washington Post* ran a story this week about a little boy named Dooney. Six-year-old Dooney spent a significant part of his life in a household where drug use and drug trafficking was a daily ritual. This heart-wrenching story illustrates the addictive nature

of crack and the tremendous impact its addiction can have on family and love ones.

As a Nation we should be able to help individuals like Dooney grow up in an environment free of the burden of illegal drug use and open drug marketing. No child in the country should have to endure that kind of life.

Recently I spent a good part of a day looking at the face of drugs in Chicago, and what I saw was grim. I wish every citizen could spend one day talking with people in law enforcement, meeting addicts, visiting with parents, traveling with police officers trying to enforce the law, and actually seeing drug transactions taking place in broad daylight—the total impact is devastating.

I came away grateful for the people who are willing to stand up, but discouraged by the immensity of the problem.

Last year I pushed hard to help enact the Omnibus Drug Act that Congress passed and President Reagan signed into law. This bill recognized there aren't going to be dramatic answers. The provisions I authored included a $30 million grant program to help youths move away from gangs and drug abuse and a demonstration project targeting pregnant women who are drug addicts for treatment and education.

If we are going to attack the drug problem in America, we must reduce the demand for drugs through comprehensive education and effective treatment, as well as tough law enforcement. One cannot work without the other.

I offer 10 common-sense suggestions for stepping up the Nation's war on illegal drugs. These 10 pieces of the drug puzzle include:

- Encouraging "everyone" to become involved in drug education—parents, teachers, churches, synagogues, service and community-based organizations—in an all-out effort that would parallel the success of the anti-smoking campaign.
- Making treatment available on a timely basis to addicts.
- Taking to self-described "recreational users" the message that they are just as much a part of the problem as are addicts.
- Law enforcement authorities must go after more than the drug trafficker, throwing the full weight of the law at the person who sells drugs, but also dealing swiftly and imposing heavy fines on the user.
- Trials for those accused of drug trafficking should be set as quickly as possible so the penalty is prompt and severe.
- A convicted drug trafficker should stay in prison during an appeal.
- Authorities need to get tough about drug use in high-rise public housing.
- More telephone hotlines are needed so anonymous tipsters can report information about drug dealing.
- The United States should do all it can to discourage drug production in other countries, including economic penalties for producer countries that don't cooperate.
- A host of "small things" every citizen can do like shunning businesses that contribute to illegal drug activity.

I look forward to hearing from the witnesses at today's hearing on how we can effectively deal with the drug crisis in America.

I believe we can significantly reduce the drug problem in this country if we provide leadership to the American people and dedicate the financial and manpower resources this great Nation has at its disposal. The time to act is now. We dare not give into this matter.

The CHAIRMAN. We have a full hearing this morning. I have been informed now that we are going to have some votes as we go through the morning, so we will try and make the record and invite our witnesses to be as succinct and direct as possible and we will try and move it along. We know many have come many miles, so we are very appreciative of their willingness to share their experience with us, but we will try and move the hearing along.

For our first witness, I want to welcome John Lucas, one of our Nation's renowned athletes, one of the most honored basketball players in the history of the University of Maryland, No. 1 draft pick in 1986 NBA draft, who played with the Houston Rockets, Golden State Warriors, Washington Bullets, San Antonio Spurs, and Seattle Supersonics. John has the distinction of excelling in two pro sports at one time, tennis and basketball.

He is also head of the national nonprofit group called Students Taking Action, Not Drugs, which has helped students to stay drug-free. John has shown the success that athletes can have as a positive role model in teaching youth to choose activities such as sports over drugs.

Then we will hear from Delvin Williams. I am pleased that Delvin has joined us. Delvin was a professional football player for the Miami Dolphins and San Francisco 49ers. Upon retirement from football, Delvin organized a drug prevention program for youth called Pros for Kids. His most recent project is a 3-year high school pilot program in California, which developed a successful curriculum to teach youths self-esteem and avoiding drug use.

Mr. John Lucas, we are glad to have you, a person aware. I can remember the times that you were good enough to join and play tennis for the Robert Kennedy Memorial. Everyone always wanted you on their side, and I was never fortunate to have that opportunity, but perhaps at another time we will get Dr. Steve Keith, who is a valued member of this committee and has just about as good a cross-court back hand drop-shot as you ever want to see.

I will ask my colleague if he wants to say a word.

Senator HATCH. I will just put my statement in the record.

I want to commend you, Mr. Chairman, for holding this hearing. I certainly welcome both you, John, and you, Delvin. We have some mutual friends, I just want you to know that, and I appreciate having both of you here and appreciate your testimony today.

[The prepared statement of Senator Hatch follows:]

PREPARED STATEMENT OF SENATOR HATCH

Senator HATCH. Mr. Chairman, I want to commend you for holding this hearing—which I hope will be the first of several—on our Nation's drug problem. There is no question that this issue is on the minds of our citizens, and we should not become complacent here in the Congress just because we have already enacted the Anti-Drug Abuse Act of 1988.

We are all pleased with the steps that have been taken thus far to implement the provisions of this comprehensive measure; but, we cannot stop now, brush the dirt off our hands and say we are done. We cannot say we have solved the problem.

Every American is touched by the drug problem in some way. Perhaps an individual has battled his or her own addiction or has coped with the addiction of a loved one. Some citizens have been in accidents involving people driving or operating machinery under the influence of drugs, including alcohol; and, some have been the victims of crimes that have drug use at their core. We are all concerned that our doctors, airplane pilots, school teachers, or police officers are not drug users.

And, I am particularly touched, Mr. Chairman, by those babies who are born with an addiction to drugs or alcohol. I have seen the children being treated for fetal alcohol syndrome at the Primary Children's Hospital in Salt Lake City. These children—who are the future of our Nation—never even had a chance to say no.

I would like to commend the "Baby Your Baby" project which is a multimedia educational program sponsored by a number of organizations in Utah, including Blue Cross/Blue Shield, the Utah Medical Association, the March of Dimes, the Utah Department of Health, and KUTV in Salt Lake. This program is dedicated to bringing home the fact that drugs, including alcohol use among expectant mothers, lead to the addiction of newborns and contribute significantly to infant mortality. It is but one field of battle in my home State.

Drug abuse casts a pall over so much that is good in our country. Athletic competition is compromised. Young people become disinterested and drop out of school. Executives risk their careers. Neighborhoods become war zones. Families break up. Clearly, the war on drugs is a war we must win if we are to stop this erosion of traditional American values. But, the war on drugs will demand determination, as much as it will need funds.

The kind of community teamwork exhibited by the "Baby Your Baby" project in Utah is forming the base for our national attack on drug and alcohol abuse. It is encouraging to realize that solutions are being found. I am grateful to our witnesses this morning who have offered to share their personal stories and to apprise us of other promising local efforts. This testimony will help focus our continued efforts in the right direction.

The CHAIRMAN. Very good.

## STATEMENTS OF JOHN LUCAS, DIRECTOR, STUDENTS TAKING ACTION NOT DRUGS (STAND), HOUSTON, TX, AND DELVIN WILLIAMS, PRESIDENT, PROS FOR KIDS, BURLINGAME, CA

Mr. LUCAS. Thank you very much.

It is indeed an honor to come before you today. I welcome the opportunity to share my experience, heartbreak, addiction and recovery. I am overly qualified to speak to you on the subject of drugs, alcohol, and the problems that stem from addiction.

For 16 years, beginning with college at the University of Maryland and 13 years of professional basketball, drugs and alcohol

were a priority in my life. I went from stardom to depression and near destruction. I know first-hand what it means to "hit bottom."

When I was suspended from the Houston Rockets in March of 1986, it was my bottom. I went into treatment for the third time. I came close to losing my family, my peers were cautious about associating with me, and my friends and I were not alone. I found myself more alone than I can comfortably describe. As I reflect upon the events, there is too much pain.

When I returned from treatment in the summer of 1986, I began to research what I could do to stay sober; my sobriety had replaced the priority of drugs and alcohol. I began to attend AA meetings religiously, I started fitness programs in Houston hospitals, helping recovering addicts and trainees bridge the economic gap and to allow the substance abuser an opportunity to work on his physical image, as well as his mental well-being. It is through helping others, turning away from too much self, that I began to feel at peace and understand my disease, and truly it is a disease. But not only does John Lucas have this disease, the country now has it, with no known cure.

Today, in addition to professional basketball, I am president of an organization working with children and adolescents, helping them to provide support to each other. I will speak more to the subject of STAND, Students Taking Action Not Drugs, later in my testimony.

For many years, addicts who participated in drugs felt they were entitled to do so, it began as a social event, then spilled over into the home, where the future of our country, "the little ones of America," our youth, were observing.

The double-message syndrome begins with parents saying don't associate with Johnny because he does drugs and is a bad influence. Little did the parents of today realize they too are a bad influence. The media allows liquor commercials and sponsorship of all our great sports activities; there are more "lite" commercials than there are lights on the White House Christmas tree.

Kids learn from watching us. A painful example relates to my daughter Tarvia, then 6 years old. She used to watch her father snort cocaine in his house and, imitating her daddy, she used to take ashes out of an a `tray and pour them through a straw. Guess who she was imitating.

My son John, 3 years old at the time, dressed in his suit, he normally would dress his own self and he would be dressed in all plaids, placing orange juice in his duffel bag, because his dad always placed his brew in his duffel bag. These are painful examples of our youth today, and we never really realize or knew the impact that Spuds McKenzie, the original party animal, had, but little did we know that Spuds died from an overdose of tranquilizers.

There are many examples that would frighten most of you, but it is happening every day.

We ask ourselves the question, is this a moral issue, economic, or is it a social issue? It is all 3. It is yours and my moral issue. We must do anything and everything to teach our kids the dangers of drug usage, and I use the word "drug" in generic terms. It includes alcohol. Alcohol is a drug. It just happens to be legal.

It is an economic issue, it is big business for the drug kingpins of the world. It is more money than a kid from Harlem, Chicago or St. Paul has ever seen in his life. To push drugs is an opportunity to buy himself designer jeans and a car. How can you turn it around? Early education, if it is not too late.

Is it a social issue? You judge. Webster's Dictionary defines "social" as the interaction of the individual and the group, or the welfare of human beings as members of society. My vote is yes, the welfare of our youth must be protected. When we protect and prevent harm to our youth, we protect the future of America. The problem, unfortunately has reached epidemic proportions, so we must move as rapidly as possible to put into place a plan of prevention that is realistic and attainable.

I would like to share some statistics with you that are alarming. They are taken from the *Commission News*, published by the Texas Commission of Alcohol and Drug Abuse.

Each day, in the United States, 5,000 people try cocaine for the first time; 2,700 boats and planes are used to smuggle drugs into the country, and nearly 2,000 Americans will be arrested for drug violations.

Eighteen million U.S. adults are problem drinkers, and there are 29 million children of alcoholics who are three or four more times likely to become alcoholics themselves than are children of nonalcoholics.

Alcohol is involved in 52 percent of all murders, 57 percent of all rapes, 53 percent of all assaults, 63 percent of all burglaries, and 55 percent of all thefts.

McCord adds that, by the time children are 18, they will have seen more than 100,000 alcohol advertisements on television alone.

Name that booze—young children can name slightly more alcoholic beverages than presidents, according to a survey conducted by the Center for Science in the Public Interest.

The average 8- to 12-year-old in the Washington, DC area study could name only 5.2 alcoholic beverages, but only 4.8 presidents. The children consistently spelled the alcoholic beverage brand names correctly, while listing such presidents as "Nickson, N-i-c-k-s-o-n," "Rosselvet, R-o-s-s-e-l-v-e-t," "Aprilham Linchon, A-p-r-i-l-h-a-m L-i-n-c-h-o-n," and "President Ragon, R-a-g-o-n." Budweiser, Miller Light, Bud Light, Coors, and Bartles and James, which was spelled with a "y," were the most commonly cited products.

Prevention, of course, is the ideal solution, but the disease is already ripe. Prevention comes from the future generations. Today's alternative must be found that is more appealing than the high glamour and money of drugs. The only thing that is stronger is life itself. We must educate the user that he has designed a limited pathway for himself, it is either death or jail.

We must begin with real education to the parents, legislators, judges, and most of all, support and education for the educator. The process will be slow, but it can happen. A mountain can be chipped at by an individual and never make a dent. A country of concerned Americans can topple the mountain.

It will take manpower and money strategically placed. It will take Congress and the legislative body enacting tougher laws and

law enforcement committed to protecting the youth of our community.

Further actions related to the solution must come in support of the ex-abuser, to keep them removed from the arena of addiction and place them in a position to be role models and teachers.

A small contribution to our Houston community has occurred through the efforts of the organization of STAND, where kids truly come together at school and provide peer counseling and support for each other. The support groups of Students Taking Action Not Drugs is in a small way their AA or Narcotics Anonymous meetings.

Coalitions are started in schools, churches or both that can provide a place to come year-round. The kids run it, but know there is an adult sponsor they can go to, if needed.

There are rare cases when a kid has slipped and gone back to drugs, when you have demonstrated love and caring by doing.

For the State of Texas alone: $2 million in fiscal year 1990 and $2 million in fiscal year 1991, to be expended for the expansion of prevention services for youth; $2 million for fiscal year 1990 and $2 million in fiscal year 1991 to be expended for the expansion of intervention services for our youth; and $6 million for fiscal year 1990 and $6 million in fiscal year 1991 to be expended for the expansion of institutional, residential and intensive outpatient treatment programs for our youth.

If each State follows suit, we will have a beginning, but the problem must not be just the problem of the nineties. There must be continuity and the efforts cannot wane. We must maintain our commitment to the future.

Look at organizations like STAND, industries to sponsor healthy drug prevention programs. STAND behind your youth and our youth of today and they will have the same gratitude as I, John Lucas, have today.

Thank you.

The CHAIRMAN. Very good.

Delvin Williams.

Mr. WILLIAMS. Mr. Chairman and members of the committee, I am very pleased and thankful to have this opportunity to participate in today's hearings and to address the most critical issue facing our Nation, that of substance abuse.

In the next 5 minutes, I will try, as clearly as possible, to give you some background on my history, my life and what I am doing today, in hopes to shed some light on a possible solution for some of the problems among our athletes and youth.

My name is Delvin Williams. I am originally from Houston, TX. I went to the University of Kansas. I graduated in 4 years, was drafted in the second round by the San Francisco 49ers. I played 4 years with the 49ers, was all-pro there, was then traded to the Miami Dolphins, played 2 years in Miami, where I subsequently had a problem with cocaine.

I ran into all of the critical problems and issues that most athletes run into, the lack of trust, the lack of support by an organization, the feeling of being betrayed—all of the natural issues that may lead one into the problem of substance abuse.

For 2 years, in Miami, I abused cocaine very heavily, until my last year there, was finally released by the Dolphins, so I came back home and started putting my life back together and received help through psychological meetings, not only in San Francisco, but even while I was in Miami.

At the time in Miami, there was no process or solution in place to systematically help athletes deal with the problem of substance abuse in their lives. Upon coming back and having looked at my life and getting my life back in some kind of order, I wanted to do something and give something back to kids and to help someone else benefit from the problems that I had experienced.

So, in 1982, I started a program called Pros for Kids, and co-founded that program, along with Larry Schreiber. Larry was also a San Francisco 49er and was traded to the Chicago Bears.

My problem that I had was one that I think most athletes share, in that there was a lack of preparation for the life that we were living for the immediate success. As a young athlete, I had never had a checkbook in my life until I turned pro, and I think for most of us that are in professional sports, we are faced with that issue.

The solution, in my opinion, was to try and get kids to understand the nature of playing sports, to not be the athlete that they see on Sunday, but to also make life come alive to them, to what it takes to be an athlete from Monday to Saturday.

So, we started Pros for Kids in 1982, and now we have been in 12 schools in the State of California with a pilot program. Over the last 3 years, we have developed a curriculum to use athletes as positive role models.

Now, in my opinion, if we are taught as athletes with the same zeal and same fervent practice that we are taught to be professional athletes, if we are taught to be role models, I believe that athletes can rise to that occasion and be role models. But the majority of the problem in most of us today is that we have never been taught to handle that position.

In 1986, we got a grant from the State Department of Education to do just that and to develop a curriculum to use athletes in the schools. Over the last 3 years, we have developed an 8-week curriculum that trains athletes to go into the schools and deliver this 6-week curriculum, based on self-esteem.

Over the last 3 years, we have been evaluated by the Evaluation and Training Institute and was contracted by the California State Department of Education to conduct a third-party external evaluation. We have just received their final report, which is here which will be entered in the record, and here are some of the findings that ETI has come up with:

Forty-two percent of the students who responded to the post-test questionnaire stated that, since participating in ON-TRACK, they have used less drugs than before the program.

Nearly two-thirds, 64 percent, reported that, because of the ON-TRACK program, they had decided not to use drugs and alcohol or to start using drugs or alcohol.

When asked if they knew more about drugs and alcohol, 71 percent said yes, and 73 percent stated that they learned how to say "no" to drugs and alcohol when they were off of them.

Thus, the student data from program year 3 indicated that Pros for Kids had successfully achieved one of its foremost goals, to reduce substance abuse among senior high school youth.

We are very pleased with the outcomes of our independent evaluators' report.

In conclusion, Pros for Kids is proud to have fulfilled the obligation of the California State Department Education and to have finished the 3-year pilot program with a proven successful and effective substance abuse prevention program.

Pros for Kids is currently requesting funding from the California State Legislature for 1 year to field test the curriculum and implementation of the program in new schools. Our goal is to have ON-TRACK available for all California schools by fall of 1990 and to provide a model for a nationwide substance abuse education program.

It is my belief that athletes can make a difference if we are taught and trained properly to do this. I believe that if we can take the college and university athletes and train those athletes to have that kind of effect in their community, as well as professional athletes, I think we can make a big impact on this problem of substance abuse.

Thank you.

[The prepared statement of Mr. Williams (with additional copy) follows:]

## PREPARED STATEMENT OF DELVIN WILLIAMS

Mr. Chairman and members of the Committee, I am very pleased and thankful to have this opportunity to participate in today's hearing and address the most critical issue facing our nation, that of substance abuse.

My name is Delvin Williams and I am President and co-founder of Pros for Kids in California. I'm probably more well known for my career as a professional football player from 1974 to 1980 when I was an All-Pro running back for the San Francisco 49ers and the Miami Dolphins.

I grew up in Houston, Texas and went to the University of Kansas where, after being academically ineligible my freshman year, I graduated in four years. With a highly successful college football career at the University of Kansas, I graduated in 1974, and was drafted in the second round by the San Francisco 49ers. I led the 49ers in rushing three of four years and was selected All Pro in 1978. Besides my success in football, I was very happy in San Francisco and excited about my future.

When I was traded from the 49ers to Miami in 1977, it was a perfect substance-abuse setup. The pressure was on, for I was the missing link to take the Dolphins to the Super Bowl and the press was all over me as soon as I stepped off the plane. Although I was successful in Miami, again selected All Pro in 1978, eventually the pressure, the strange environment and contract problems led to my abuse of cocaine. At that time there was no process or system in professional sports to help me overcome my problems, so by 1981 I was out of football and had to confront my addiction on my own with the help of a psychiatrist both in Miami and when I returned to San Francisco. I eventually learned that my problems could have been avoided with the proper preparation into professional sports and knowledge of some general but critical life skills.

When I put my life back together, I decided I wanted to give something back and help other athletes and children to avoid the problems of substance abuse. So, in 1982, I and a former 49er teammate, Larry Schreiber, founded National Sports Career Management which evolved into Pros for Kids.

National Sports Career Management (NSCM) was developed to help prevent substance abuse among professional athletes, as well as among kids. Through a contract with the USFL, NSCM provided an orientation, a toll-free phone number for counseling referral information, and drug information pamphlets. NSCM also provided summer camps for kids which taught both athletic skills as well as substance abuse prevention.

In 1985, we changed our name to Pros for Kids and decided to focus on our youth. Pros for Kids is a substance abuse prevention program established to prevent drug and alcohol abuse

among young people through critical life skills training and the development of game plans for life which preclude substance abuse.

In 1986, Pros for Kids entered into a contract with the California State Department of Education to develop a substance abuse education curriculum for California high schools. This curriculum, ON-TRACK, is our major program and uses professional and amateur athletes as role models in the high school classroom to teach youth that personal responsibility and motivation are required to get your life on track and achieve personal success. The contract provided for the pilot-testing of the curriculum development in 12 high schools in California for three years.

High schools were established as the major target group for Pros for Kids in that research shows that incidences of drug abuse increased drastically between ninth grade and graduation with few programs to address this problem. The majority of prevention programs concentrate on lower grades trying to attack the problem at an earlier age and also avoiding the challenges of working with high school students.

The high school program consists of a school-wide assembly program which features several athletes who provide an introduction to ON-TRACK and increase student awareness of the pitfalls of drug abuse. Other school-wide activities include teacher orientation, a parent forum, an athlete symposium and safe celebration events.

The in depth portion of the program is offered to incoming freshmen. Working with the school, a subject area is chosen in which the program is to be implemented. Working with the teachers in this subject area, specially trained staff athletes then provide eight sessions in these classrooms and address self understanding, goal setting, mental and physical preparation, development of support systems, and action planning.

At the junior high level, the ON-TRACK program provides assembly programs and summer camp programs. The assemblies, also provided by a team of athletes, stresses the importance of selecting appropriate role models and having resistance skills in saying "no" to drugs. Pro Camps are non-residential, one-week summer programs for boys and girls. At these camps, celebrity and amateur athletes not only provide coaching in a variety of sports but assist in the classroom program which provides increased awareness and resistance to substance abuse.

The after school, elementary program is Pro Clubs which primarily uses college athletes to serve as group leaders. Through athletic participation, field trips to sporting events, and lessons related to self-esteem, decision making, and drug information, young people gain the necessary attitudes and skills for reducing the liklihood of becoming substance abusers.

The Evaluation and Training Institute was contracted by the California State Department of Education to conduct a third party external evaluation of the ON-TRACK program in the high schools. The purpose of the third party evaluation was to: " 1) determine the extent to which the program achieved its specific goals and objectives; 2) describe the means of implementing the program at participating schools; and 3) provide recommendations for improvement."

The Final Report was just recently issued and, Mr. Chairman, I would like to submit a copy of this positive evaluation for the record. A brief summary of the major findings from the third program year include:

1) Forty-two percent (42%) of students who responded to the posttest questionnaire stated that since participating in "ON-TRACK", they used less drugs than before the program.

2) Nearly two-thirds (64%) reported that because of the ON-TRACK program they had decided to not use drugs or alcohol (or to stop using drugs or alcohol).

3) When asked if they knew more about drugs and alcohol, 71 percent said yes. Seventy-three percent state they learned how to say "no" to drugs and alcohol when they were offered them.

4) Thus, the student data from program year III indicate that Pros for Kids successfully achieved one of its foremost goals: "to reduce substance abuse among ... senior high school youth."

5) The student groupings responding to the pre- and posttests were evenly split between males and females.

6) The ethnic makeup of the students responding to the pre- and posttests were very similar, with differences of only a few percentage points.

Pros for Kids is proud to have fulfilled the obligation to the California State Department of Education and to have finished the three-year pilot program with a proven successful and effective substance abuse prevention program.

Pros for Kids is currently requesting funding from the California State Legislature for one year to field test the curriculum and implementation of the program in new schools. Our goal is to have ON-TRACK available for all California schools by Fall of 1990 and provide the model for a nationwide substance abuse education program.

The CHAIRMAN. Thank you very much.

At some time you must have made the decision, both of you, to stop. Can you translate that judgment, that determination when you finally said you were going to stop, to other abusers or to kids?

Mr. LUCAS. Senator Kennedy, for me, I was tired of living that way. First of all, addiction is a disease of denial, that tells me that I did not have a problem. I blamed everybody else for my problems. It took my dreams and eventually it took my soul.

What I try to convey to the youth today is that it is best to never get started, but the problem is when does it become an abuse. Is the first time that you have ever used it? And what happens to our youth today? The problem is they do not have the right choices to make and know how to want to accept who they are, which I could not do. I lost believing in something greater than myself and caring about the next individual.

The CHAIRMAN. Delvin.

Mr. WILLIAMS. Would you repeat the question, Senator?

The CHAIRMAN. You at some time made the judgment and the decision to stop. You might have made it 2 or 3 times or whatever, but is it possible to translate that decision that you made to kids or to other abusers? And if you can, how do you do it?

Mr. WILLIAMS. I think with me personally, I got tired of—there were several of us, we would always sit around and we would look at each other and we knew that we were abusing drugs and we were abusing our body. I think it gets to a point with each individual, as to what is their bottom, when do they feel as though they have done all of the things that they could have done or should have done.

For me, I think you cannot convey that to kids. I think they do not have to experience the bottom that we have experienced. I think we have to look at each individual and help them to understand the situation that they are in and help them to identify some of the causes, if you will, that might be entering into their life, just causing them to use drugs.

For some of us, we come from addictive families, where we come from—the problem is varied, is multifaceted, so we have to look at each individual to find out what their individual problems are.

The CHAIRMAN. Can you talk for just a moment about the glamour of sports and also the difficulty that some of the great sports stars and current sports leaders have? For example, the publicity of Ben Johnson, Len Bias, and others? What is your message to kids? As a famous athlete yourself, how do you try and communicate your own concern that kids do not look at great athletes and also the substance abuse as all being part of success, or can you?

Mr. WILLIAMS. I think for me, personally, that is very, very hard, to try and convey this to kids. Even though being an athlete, I was only a kid myself in terms of mental development and understanding the nature of the job that I was in.

I think there has to be, particularly in sports, there has to be systems in place that are educating and training athletes as to the nature of the problem that comes with their job, that asking us to become businessmen overnight, when we have never had a checkbook in our life, some of those kinds of things have to be put in, not only for athletes but also for young kids, to help them to under-

stand what life is like, and not just a sport, because we become a victim of the sport and all of the things that come with that, the hype, the tension, the things that we are not prepared to handle leads one into substance abuse.

The CHAIRMAN. So, clearly there is a role for those colleges, universities or education centers, where many of the athletes come through, although not all.

Mr. LUCAS. Senator Kennedy, for me—and I am addressing kids, I am on the NBA's Reinstatement and Drug Committee in establishing new rules. What happens is, this year, the education that was done to educate our players is going to be different the following year. As you hit the nail on the head, it has its start in college and in junior high school. We have to start educating not only athletes—I have to convey to kids all the time that basketball is my job, it is not who John Lucas is. I am more than just a basketball player, I just happen to do that as a trade.

But the money that comes from sports, we have to learn not to compete in life, but to compete on the floor, and drug addiction and alcoholism is an ego problem, it is competition, get the biggest car, get the biggest house, succeed, succeed at any cost.

You know, one of my biggest problems, why I drank is because I played with a Nigerian who talked funny and cursed me and I could not do that, and he was 7 feet tall, so I had to accept who I was, because when I got drunk I could imitate him but I was not him.

The CHAIRMAN. Let me ask, finally, because my time is up, if you talk a little bit about the importance in early education to build the kinds of skills, to be able to make choices, to begin to develop some confidence? How important is that in terms of your own programs—as you both were involved in important programs that are having some successes? Can you speak a little bit about that? Is that important? Is it important to start early? What could you tell us?

Mr. LUCAS. I teach our kids at an early age—and I use my kids because I can tell you what I do with them—the ABC's of life. There is no medicine for drugs and alcohol. It is acceptance of who she is, believing in something greater than ourself and caring about the next person.

She wishes to wear designer jeans at 8 years old, and so I took her shopping to buy some jeans and the jeans had no label on the back of them, and so she began to cry and not want to go to school the next morning, because her girlfriends all decided they wanted to wear designer jeans. So, when she came down in her jeans, she was crying and I said, "What's wrong, Tarvia?" Tarvia said, "Well, dad, I can't go to school, all my peers and I, we are wearing designer jeans today." I said turn around, and I went and got some tape and I taped on the left-hand side of her jeans, in the back, a big old question mark, "Guess who's jeans?" It is not important, what she has on or what she is doing. The most important thing is she accept who she is, and that is what we have to do, is get our kids to accept who they are, where they come from, and begin to fight and live and hold onto their dreams. That is our solution.

The CHAIRMAN. Delvin.

Mr. WILLIAMS. I have a cousin right now, I guess he is a junior in high school in Houston, as a matter of fact, and he is in a family where both parents are using crack and I am like the role model for him. I think it is very important that that kid has someone to look up to, someone for direction to help instil in them some sound values and what it is going to take to make it in life.

I think it is very important that we start at a very early age. I do not think we are starting early enough. I think we should have all of our books, health books thrown out and reeducate everybody, from K–12th grade, about all of the substance abuse issues that young kids are faced with.

This kid is learning the hard way. He is learning and I am trying to reach out to him and help him. But I do not believe that—and I think that each kid does have, there is an opportunity to them to get through this, even though it is around them, with the right kind of support and the right kind of information and education.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

I want to compliment both of you for being here today. Every American is touched by the drug problem in some way. You know, perhaps an individual has battled his or her own addiction, as both of you have done, or has coped with an addiction in some loved one. Some citizens have been in accidents involving people who were driving or operating machinery under the influence of drugs, which would include alcohol. Some have been the victims of crimes where, of course, drug use was at the core of that.

We are all concerned that our doctors, the airplane pilots, school teachers and police officers are not drug users or drug abusers. But, I do not know in this society any group of people that probably has as much influence on the youth as professional athletes. In fact, you have a lot of influence on all of us, especially some of us really admire the talents and abilities that you gentlemen, in particular, have displayed and I want to compliment both of you for your tremendous physical abilities to excel at the sports that you have been in.

More importantly, both of you have been to the depths and you have both come back, and I want to compliment you for that. I think it is a terrific thing that both of you are doing, that you are willing to appear here and testify before us.

I appreciate what you are trying to do, Mr. Williams, in working with youth and trying to help others to become role models, and I think that is great.

Now, would each of you just kind of comment on how old you think children should be before we should start educating them concerning the problems with drugs.

Mr. LUCAS. Well, I think it is never too young to start to educate our kids. You know, by the time kids are in the 5th grade, they have decided whether they want to take a drink or a drug, so we have to continue to educate our youth at an early age. It should start, as Delvin, said at K–12th grade and it should be a continuing program. It is not just to say "no" once, you have to say "no"—I am in meetings with kids all the time, kids that are 10 years old to adults that are 80 years old, and it is a living problem.

Somewhere in life, I stopped coping with life and living life on life's terms and decided to medicate the feelings. We have to get our young adults and our young kids to get in touch with their feelings right away, as early as possible.

Mr. WILLIAMS. I agree with John, I think we cannot start too early. I think, particularly, the parents are the role models. They say as athletes, we are the role models, but I think parents are the true role models and they start to set the example for kids at a very early age in terms of coffee, cigarettes, the one martini or cocktail when they get home, and we try and say that those are not drugs to kids and we are giving them contradictory messages, so I think we cannot start early enough in educating kids about all drugs, not just illicit drugs, about all drugs.

Senator HATCH. Well, you two are both role models for our young people and many others to boot. How do we get top athletes in professional sports involved in fighting this problem that exists in professional sports today of drug use and drug abuse? How do we go about that?

You mentioned that for many of these star athletes, the first time they have ever owned a checkbook is when they get drafted out of college and get a job playing professional sports. How can we help solve that problem and what should we be doing here, if we can?

Mr. WILLIAMS. I think it is more or less an institutional problem. We call on our friends as athletes to come out and assist and help us, but I think we have to look at the institution of sport in our society and how it functions and how it trains and educates its athletes, and I think we have to try and convey to sports institutions, not only professional but college and even at the high school level, to start instituting those kinds of training and educational programs for their athletes, and that has to start from the ground up.

A lot of athletes and a lot of us did not realize the power that we have or had as role models until we got out in life and did whatever we have done to destroy that, and then we looked at the impact that we can make, but that is too late then. I think we have to start from the time we put the helmet on or pick the basketball up, with educational approaches to our responsibility as athletes and to the problems that come with playing the sport.

Mr. LUCAS. I think that one of the problems I have is two-fold. Whenever I ask other athletes or my friends to speak for our organizational stand, I do not want a double message. That means they can say they do not do any drugs, but I include drugs meaning alcohol. Being athletes, we are disciplined to take care of our bodies, but we think that because our bodies are so finely tuned that the mind does not need to be as healthy, so when we are asked to speak we do not want to give any more double messages.

You know, for a long time our parents used to tell us, "Don't do as I do, do as I say," so we do not want the double message of athletes.

The next thing is sometimes we just need to ask to have them get involved. You know, sometimes we do not even just ask. I asked Michael Jordan this year to speak for STAND, and he did. I just asked. Sometimes we need to take the step and ask our sports stars to become a part of it.

Senator HATCH. And I think people like you can do that.

Mr. LUCAS. Yes.

Senator HATCH. I have a lot of respect for both of you. I know what you have been through. I have watched your career, John, for years and I saw the ups and the downs, and yet what a tremendous basketball you have been.

And I have watched you, Delvin. You are a mean person out there on that field, is all I can say, and you were good. But let me just say this: I really admire people like you. I hope that our new Drug Czar Bill Bennett will consider getting professional athletes involved, not just to go out and be examples to youth but to participate and get around this country, also to get them involved in solving problems within professional sports as well, so you can continue to multiply the groups of people who really can get out and be examples to our young people.

So, you gentlemen can set some real standards here and I think you can do some very, very important things. I have asked my friend Muhammed Ali to get involved in this area. He is willing and all we have to do is ask him.

I feel very privileged to be here today and I am very happy that you have been willing to come and testify before the committee.

My time is up. Thank you.

The CHAIRMAN. Thank you.

Senator Adams.

Senator ADAMS. Thank you, Mr. Chairman.

I want to echo how pleased I am that you are both here today and I would like to have you answer a question for me, because it is the same one that Senator Kennedy asked, and we have a particular reason for asking it, and that is that we are about to pass a series of bills to deal with the District of Columbia, which is being described as a "murder capital," it is being described as a "crack capital." We have a terrible problem that it is here and it is in the schools, and that is any information that you can give us as to how we can treat or break the crack addiction habit in the young people, particularly the high school age and below.

I am so grateful that you are here to talk prevention, because I think that is the only way, that is the solution that is there.

You mentioned, John, in your statement, that you started the AA meetings, you started the fitness program. We are faced with the fact that our crack addiction is multiplying here. Is there a way that either of you can suggest of what we should be doing to try to stop that in the treatment area?

Now, we have already got the prison area and we are going to go for more police, we are going to go for more courts, but we all know that that is a dead end. You mentioned that that is necessary, that everybody knows that the end is either death or jail. But you mentioned that you went to the meetings, you started a fitness program, in other words, you went to your body and your mind and you did something, and that is really what the Chairman was asking and I am asking you the same thing. What do we focus on that we can be helpful to make that change occur?

Mr. LUCAS. Well, I think that you could add in the school curriculums drug education programs, but the proper drug education

programs in the curriculum. Those that are already addicted, we have to educate them of the harm that is happening.

But the problems stems that we have to continue to have—I do not want to sound redundant—the prevention education, to show them the evils that it will do, de-glamourize drugs and alcohol.

In the District of Columbia and the Washington area, it is all around and very prevalent. What we have to continue to do is fight this problem one step at a time. There is no one solution, Senator Adams, as you know.

Senator ADAMS. I know.

Mr. LUCAS. But what we can do is we can continue to educate within the curriculum and begin to give the recovering crack addict a safe place for them to come and talk about their problems. You see, somewhere down the line——

Senator ADAMS. That is one that I need and I want my staff to note it, a safe place to get out of the—you see, I did the same thing with my kids that you are talking about with yours, because I happened to be a prosecuting attorney trying a case at a particular time and there were a lot of people in there that had coke addiction and some of them fell off the witness stand, and I just said to kids "it's death," and you know, described their limbs twitching and so on.

But I am trying to focus now, and I think a safe haven, a change in——

Mr. LUCAS. Environment—our organization STAND is geared toward the nonuser, the guy that is dibbling and dabbling with drugs and the recovering kid. We have all three, we bring them all three together to talk about the positive alternatives of not being involved in drugs. We have seen great success in having all three, because those that are addicted seeing those that are dealing with the same living problems without using drugs and alcohol.

We have to begin to get our kids talking to kids and begin to have some peer counseling among themselves, but the proper kind of peer counseling. We have to have the peers being told how to talk to addicts and alcoholics. You know, it is one thing to see an athlete, but it is another thing to see another kid talk to another kid about drugs and alcohol, because that is another kid, somebody they can relate to on a daily basis.

My goal was to be President of the United States, the next John F. Kennedy, at 14, but I could not run for president until I was 35—please pass me another beer, I've got 18 years before I could even run. So, we need to base it on living their life one day at a time and have them with positive people who are not using drugs, those that are dibbling and dabbling, why they stopped or why they continued, and let them see the outcome themselves. But we need our kids talking to kids and that is what STAND does. We have our kids talking to kids.

Senator ADAMS. Thank you very much.

Thank you, Mr. Chairman.

Mr. WILLIAMS. I would like to respond to that.

Senator ADAMS. Yes, please do.

Mr. WILLIAMS. I agree with everything John has said. I think we also need to consider retraining and reeducating some of the kids, to give them new ways to go out and make money, give them some

hope to make a living, other than dealing drugs. I think we need to give them skills, educational skills and vocational skills, so they can go out and work, other than to deal drugs.

Senator ADAMS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

My apologies, because I was not here for the statements and so I will not take time to ask any questions, other than to say that I do think, both Mr. Lucas and Mr. Williams, you have a unique opportunity to reach young people, and no one probably feels very comfortable as a role model—and I am very impressed with what you have said—I have tended to believe that it is one step at a time and that you have to offer along the way the means to gain some self-respect and confidence through education, and it is not something that comes easily. You have to stick with it day in and day out.

I think so often we tend to believe we can try something for a couple of months and if it does not work we leave it and move on. It is not always glamorous, it is very difficult and I really respect what both of you are trying to do and I think that it does offer a very special opportunity.

I would also like to say, Mr. Chairman, that as a graduate of the University of Kansas, I am particularly proud of Mr. Williams, who played football at the University of Kansas.

Mr. WILLIAMS. Thank you, Senator Kassebaum.

The CHAIRMAN. The Senator from Indiana.

Senator COATS. Thank you, Mr. Chairman.

I would like to ask unanimous consent to have my statement inserted in the record.

The CHAIRMAN. It will be included.

[The prepared statement of Senator Coats follows:]

PREPARED STATEMENT OF SENATOR COATS

Senator COATS. Thank you, Mr. Chairman.

I commend the Chairman for convening this hearing and for continuing to pursue his interest on this important topic. Our efforts in the treatment and prevention of drug use are the key to victory in a drug crisis made particularly traumatic by the fact that it selects its victims from among the young.

No other problem this Nation faces targets children so directly. No other problem so immediately threatens our future—since it destroys those who will create it.

Today, 4 out of 10 high school seniors use illegal drugs regularly. One in 12 uses cocaine. The average age for first time drug use has dropped below 13.

I am particularly looking forward to hearing the testimony of these students. Unlike many their parents, young people cannot erect a comforting shield of disbelief to protect themselves from a disturbing reality. They must live with the effects of drugs every day.

To most students, you don't have to prove the drug crisis is real. They have seen how education is disrupted by addiction. They have

seen how families are torn apart by the lies that mask abuse. They may have even seen a friend go to smiling self-destruction—convinced, until the end, that they could handle their drug use.

But no one can handle it. Millions of young men and women have found themselves in a form of slavery—slavery to temporary and empty pleasures. Their addiction is the purchase of spiritual death on the installment plan. And it sacrifices a future of accomplishment and true enjoyment—leaving its victims empty of hope and useless to their community.

Drug use might best be called the great trivializer—dissolving ambition into apathy, changing promise into passivity, and transforming leadership into lethargy. It is rejection without a program. It is a refusal of what is, without a vision of what should be.

This drug crisis requires action on a number of fronts. We need tough law enforcement. We need effective crop eradication. We need higher rates of drug interdiction. Battles must be fought at every point of struggle and need.

But when you get down to its most fundamental cause, drug use will not be ended by these things alone. When we speak of a drug crisis, we are really talking about a crisis of personal belief and behavior, a crisis of individual motivation and action. Our challenge is not just to destroy illegal substances. Our greatest challenge is to change minds—convincing individuals, especially our youth, that there is a drug-free standard we expect and demand that they meet, while providing compassionate rehabilitation to those who fail.

Our final goal must be to create a society purged of its last hints of lingering tolerance for drug abuse—and that means much more than fighting the distribution of some chemical. It means a more complex and comprehensive struggle aimed at prodding a reluctant society into conquering its own demand.

I am encouraged that not all the news from the front is bad. A study released by the National Institute for Drug Abuse earlier this week stated that the number of people using illegal drugs has fallen by 37 percent in the past 4 years.

Casual users and potential users are, apparently, beginning to just say no. They are taking note of the havoc that drugs can wreak on their lives. And they are heeding the message of society, heard in our schools, our workplaces, our churches, our government—and most of all in our homes and families—that we will no longer tolerate any use of drugs.

However, as William Bennett has noted, we are now fighting two drug wars. And while we are winning first, we have not even turned the corner in the second: The problem of chronic, addictive use of cocaine, crack and heroin. That same NIDA study noted that the number of people using cocaine at lest once a week increased by one-third. Those who are still using drugs are using more of them—especially in our poor and inner-city areas. Attacking these hard-core cases is a difficult challenge, and will require the availability of effective treatment and prevention programs.

There is no doubting that the intentions of the Congress in the drug war are admirable. But sincerity is not the measure of our success. Virtuous motives, crippled by inertia and timidity, are no match for an aggressive and profitable drug trade. There is little

value in the words of the well-meaning if they lack the resolution to act. So I am particularly disturbed that of the $2.7 billion authorized in last year's drug bill, only $1 billion was actually appropriated. And it is treatment and education, the programs we are dealing with here today, which have suffered the most from this shortfall. This is why I have joined with Senator Moynihan, Senator Nunn and others calling for full funding of the Anti-Drug Abuse Act.

With that said, we cannot throw money blindly and indiscriminately at the problem. We need to provide the resources, but those resources need to go to the places that do the most good. Within the field of treatment and prevention, we must know how our dollars are being spent. And I am in full agreement with the Chairman of this committee that we must know what is working and what is not.

I hope that our witnesses today can shed light on some of these questions, and I look forward to their testimony.

I want to also join my colleagues in thanking the witnesses here for coming forwards and displaying considerable courage in admitting a serious problem, explaining it to us, then committing a substantial part of your future to helping others avoid, live through, or work through the very problems that you encountered.

I think to some Americans it is a real paradox, when they look at people like John Lucas and Delvin Williams, and say they have got it all, they have achieved everybody's dream, they have fame and status and money and success and all the honor that come to the professional athlete. Yet probably what most people did not realize is that each of you was living your own personal hell trying to deal with the problem that you did not know how to get hold of.

I am wondering if I could just ask you a couple questions, to help me understand the nature of addiction and the problem. Do either of you feel that you had control over the initial decision to use drugs? There is such a controversy going on about whether drug abuse is genetically and biologically driven or just a matter of will. We tell kids to "just say no," but others say they do not have a choice in saying no, they are genetically driven to drug abuse. How did each of you feel about the initial decisions to use drugs? Was it something you felt you had control over or not?

Mr. WILLIAMS. Well, I first smoked a marijuana joint in the 8th grade, so I started early experimenting with drugs, and it was in the neighborhood that I grew up in, so I have always been familiar with it. When I made the decision to use drugs, I knew what I was doing. I mean, it was not that I was misled into using them. I knew what I was doing.

After a point, you go on and you think you can handle it and you think you have got it under control. It starts for social reasons and it starts after the games when you lose, it starts after the games when you win, and it continues to go on and addiction rolls and it rolls and, before you know it, you are into a vicious cycle, you want it before you go to bed—well, it is not because I am in physical pain any more, it is because you need it, and at that point in time you realize that you have got a problem but you deny it—oh, I can handle it, I can stop when I get ready, I just want to do it. I was aware.

Senator COATS. So, education—excuse me, John, go ahead.

Mr. LUCAS. Senator Coats, let me state it like this: I was addicted long before I ever had my first drink or drug. I have always had addictive behavior. I wanted to be the best athlete I could be since 5 years old. I wanted to be the best student I could be, I wanted to be the best at whatever I did. So, when I got involved in drugs, I wanted to be the best, you know, the best drug addict.

So, that is what I am saying, early education is to compete but not compete against others. That is the first part. And the second part, addiction, let me share what addiction is from an alcoholic's point of view. It is an allergy of the body, along with a compulsion of the mind. My body started long rejected the alcohol, then my mind told me I needed it, so I was always addicted. I am still--I have not had a drink nor a drug in almost 4 years, but I still have addictive behavior, and so there are other addictions that lead to the drugs. I was addicted before I took my first drink, and when I took my first drink at 15, it is the same reason I took my last line of cocaine or my last drink at 32. The reasons or difference is the living problems that gets us involved.

Somewhere down the line, I stopped coping with me or coping with life on life's terms, and my ego becomes involved and all the children of my ego, self-centeredness, loneliness, fear, anger, all those emotions stemmed me to find a way to stop me feeling this way, and drugs and alcohol medicated the feelings. Once I saw they worked and they continued to work, I used it all the way. When I felt good I used drugs, when I felt bad I used drugs, so I was addicted long before my first drink. I hope that shares some insight.

Senator COATS. It does. It seems to me that the two of you are coming at it from a different perspective. You very honestly and openly described an addictive-type personality, behavior and so forth, that almost inevitably led to that kind of thing. But for you, Delvin, it sounded like it was peer pressure and the belief that you thought you could handle it. You did not feel driven to seek out drugs. Now, correct me if I am wrong here, but you knew all the education—somebody coming into high school and telling you about drugs was not going to make any difference.

Mr. WILLIAMS. Sure, and I did. I think today we know a lot more about the problem than we did when I first started, and I do have the same feelings as John in terms of the problems of being an athlete. You know, you are in a position where you cannot say you hurt, you are at the epitome of what a man is supposed to be in our society and you cannot say you hurt, you cannot say I am tired, and so we go on, not only on the field but off the field in trying to be at all of the places or be everything or all things to all people. And all of those kinds of things going on in your life, sure, you make the choice but you still make the conscious choice of doing it, but not knowing where you are in this cycle of addiction, even if you are addicted.

For example, I come from a single-parent family. My father was an alcoholic and I never knew that. So, there is a lot of those issues that are there that I have lived through and I have gone through today. But just in answering your question point-blank, yes, I knew what I was doing.

Senator COATS. Was the final decision to say "that is it! I am going to do whatever it takes and get in whatever treatment program it takes, I am going to quit!" Was that the result of a conscious mental choice? You finally hit bottom. What brought about that final decision? If you say you did not have control in the initial stages and you could not control it through the process, what was it that happened that finally led you to seek treatment?

Mr. LUCAS. Once you get addicted to drugs and alcohol, you have to have what is called a "bottom." It is sort of like a downward elevation at certain levels. For me, I got off at the last level. I got to the point where I just said I was tired of living that way, and I was doing drugs at the time and I was running a course to be caught, because I could not stop on my own.

In order to stay sober, you have to get out of yourself and I was very much into myself, and at that particular point, for me, I just said I am tired of living, I am ready to give up basketball, I am ready to give up everything. I do not care what it takes, I do not ever want the pain of March 14, 1986, again in my life—one day at a time.

So, for me it is very simple. I remember my last drunk like it was yesterday. The pain is too great.

Senator COATS. The pain of being addicted finally becomes greater than the pain of being free from drugs, of dealing with all those other things. Is that it?

Mr. WILLIAMS. Well, for me it had gotten to a point where it started to bring people around me that I know was not the people that I wanted to be around. It was putting me in a position where people were stealing and taking from me and my getting to a point where I was about to be caught or just running myself down, my health was changing, my finances were changing, the relationships around me were running away. And after a point, am I going to continue to do this and be by myself, or go to the next level with it, or do I stop and start trying to put my life back together.

A lot of times I did not have the answer until I was seeking counseling and went to a psychiatrist and started to find out a lot of the things that was going on in my life and started gradually putting my life back together.

Senator COATS. Thanks, Mr. Chairman. I have exceeded my time here.

Thank you both for your statements.

The CHAIRMAN. Just one point that I would like to make.

What we are talking about in terms of early education really is early appropriate education. That may vary in different parts, but, for communities, if I can summarize it, as I understand what you are including in that early education are the building of various confidence skills, perhaps, at the very earliest time. You may not be teaching how to free-base, or something like that, and how to stay away from it.

But as I understand what has come through in terms of all this, is that in those early grades the goal is to help build some confidence and being able to make choices. Then as you move on through the education, you vary programs and make them appropriate. Perhaps you are doing one thing in the District of Columbia and another thing out in Montgomery County, for example.

Do I understand that when you are talking about early education and prevention that it has that kind of evolution in terms of education programs?

Mr. LUCAS. Yes, Senator.

Mr. WILLIAMS. Yes.

Senator KENNEDY. OK. We can hear you all day. And I think you have heard from the committee how impressive I think your testimony has been, but also how impressive your example has been. Our committee and the country is going to be focusing on these issues so we hope to keep in touch with you. As you were pointing out developing those changing skills that are necessary, we hope that you will share what you are finding out there that works with us. But you have given us very important information today and hopefully we can act on it.

Mr. LUCAS. Thank you very much.

Mr. WILLIAMS. Thank you.

The CHAIRMAN. Doug Hughes is the director of the Office of Substance Abuse for Dade County, FL. Major Hughes is a 24-year veteran of police work serving in numerous law enforcement capacities, including police officer and homicide detective. He has received numerous awards and recognition for his outstanding contributions and is recognized as a leader in Florida's crack cocaine problem, both from a law enforcement, treatment, and prevention standpoint. Major Hughes, you might come up.

And then we also have David Hatcher who is the supervising probation officer for Federal prisoners in the Kansas district who have been placed in drug treatment programs, condition of release and bail, probation or parole, and has a wealth of practical experience about treatment programs in this population.

Mr. Hughes, we understand you are the real developer and formulator of the Florida program, and we're looking very much to hear from you.

We are going to recess now for probably five or six minutes, and then get started. I hope if our colleagues do not have a chance to come back, they spend some time reviewing the testimony because it is enormously impressive.

We will recess.

[Recess.]

The CHAIRMAN. I ask Molly Coye to join us. She is currently the Commissioner of Health for the State of New Jersey, and she will soon be taking up a new post as Dean of the Johns Hopkins School of Public Health.

Dr. Coye has been on the front lines in a State that has been hard hit by the drug epidemic and is uniquely qualified to give an overview of the drug epidemic's impact on the overall health care system. So we will be looking forward to that. I understand you have a plane, train, or something to catch. We will proceed with you and then go on with the other witnesses. Thank you very much.

## STATEMENT OF DR. MOLLY JOEL COYE, PUBLIC HEALTH COMMISSIONER, STATE OF NEW JERSEY, TRENTON, NJ

Dr. COYE. Thank you very much, Mr. Chairman.

My name is Molly Joel Coye. I am the New Jersey State Commissioner of Health, a physician and a parent. Thank you for the opportunity to appear before you today.

In this very brief time, let me offer evidence that the drug abuse situation is very serious and that a major funding infusion would make a big difference because treatment does work. In New Jersey right now, we have an estimated 50,000 intravenous drug users, and probably about 150,000 cocaine users. Our public funds for treatment only support treatment for 6,000 people out of that total number. Our centers take care of 12,000 people so they are operating at about 200 percent capacity with the money that they have available.

The evidence is overwhelming that drug abusers want care, but can't get it.

The CHAIRMAN. Would you repeat those figures back?

Dr. COYE. Sure. We currently have about 50,000 intravenous heroin users and about 150,000 cocaine users.

The CHAIRMAN. All right.

Dr. COYE. We fund slots publicly of about 6,000, but we are actually in those centers taking care of about 12,000 addicts.

The CHAIRMAN. OK.

Dr. COYE. I am going to give four pieces of evidence that there is tremendous demand, and that if we increase funds, we really could treat more people.

First of all, from 1986 to 1988, we offered coupons, we hired some of the addicts from the treatment centers, ex-addicts, sent them out on the street to find hardcore addicts and offered them the ability to give out a coupon for the cost of detoxification. It was worth about $70 to $100. Eighty-five percent of those coupons were redeemed within a couple of months. That is how high the demand was for treatment.

Forty-five percent of the people who used the coupons, the addicts who came in for treatment, were people who had never been in treatment before, and another 40 percent were people who had not been in treatment for 4 or more years. So there was a tremendous demand.

Unfortunately, we do not have the funds to continue that program, or even to keep those people in treatment into the future. That is what has resulted in 200 percent capacity use in our centers and we have not been able to continue giving out those kind of coupons.

A second piece of evidence is this spring we started a behavioral study of IV-drug users, because we are worried about AIDS, obviously. In one neighborhood in Newark, 182 people came in off the street in 1 month asking for treatment when we opened up an office for outreach. In the first few months in two cities we have 300 people enrolled. Over 60 percent of them are positive for the AIDS virus.

This is absolutely astounding to us. The people who aren't in treatment have higher infection rates than those who are in treat-

ment. We absolutely have to reach these people. We do not have enough room or money to keep these 300 people in treatment into the future.

Third, we have a documented waiting list today in our State of over 3,000 people. To serve them all, just the waiting list people, would take $7 million, or about one third of the total $21 million that is available nationally for waiting list reductions.

Fourth, last year our school system with State support massively expanded its drug counseling and support system. They identified 7,000 students with drug problems serious enough to need referral outside the school. That is more than our total number of funded treatment slots for New Jersians of all ages, and clearly beyond our capacity to respond.

Now, in the face of this, it is critical to state that treatment does work. Drug abuse is a chronic illness, and just like hypertension or diabetes, there is no quick or single treatment or cure. Different modes of treatment focus on different aspects of the disease, and very importantly, methadone does not and should not be expected to do more than alleviate the craving for heroin. It is not a cure for cocaine, even though many people hold it to that standard.

As chronic disease victims, addicts can be expected to have many relapses, and the average hardcore addict will have a minimum of five courses of treatment before it takes, in a sense. Nevertheless, in the end, over the last 15 years, virtually every study of methadone or drug-free outpatient or residential treatment shows that it reduces substance abuse, increases employment, improves psychological adjustment of a patient, and decreases criminality. So by all of those different measures, treatment does work.

The lack of funding for drug abuse is essentially decimating our public health programs. Infant mortality is once again, despite our "Healthy Mothers, Healthy Babies" campaign and "Health-Start" and everything else, is really beginning to increase. Our maternal deaths are increasing. In Jersey City, our Maternal and Child Health Clinic finds a 20 percent cocaine positive urine screen among pregnant patients in for prenatal care, and those are the ones who do come in for prenatal care.

As you probably know, we are one of the States most hard hit by AIDS. We have 7,000 AIDS cases, and we have the highest proportion of IV-drug users among them. IV-drug users, their sex partners, and children are about two-thirds of all our AIDS cases. Syphilis has completely skyrocketed in our part of the country because of drug abuse and the exchange of sex for drugs.

Let me finish by what it is that we need. First, and most importantly and obviously is adequate funding for treatment for everyone who needs and wants help. NIDA estimates that as much as 50 to 60 percent of addicts would come into treatment if it were available. All of our experience supports that. The kinds of treatment should not be just methadone. It should be drug-free and methadone, residential and outpatient, and all of those modalities of treatment are needed.

We obviously are going to have to continue to rely heavily on public, mainly Federal, revenues until private insurers cover this service. Even then, financing for indigent patients, if we are not

lucky enough to have national health insurance, will still be needed.

Medicaid is a major problem because most Medicaid programs do not cover the single male, even under State options, and the largest group of indigent addicts are exactly those, the young males.

The second need, besides treatment money, is capital investment. We do not have enough drug treatment centers, and especially with the NIMBY phenomenon, "not in my back yard," it is just about impossible to get new ones started. In New Jersey, we have only opened three or four new centers in the last 5 to 6 years. We would like to see Federal money allowed to be used for some capital improvement or investment, and maybe some strings on the money so that it will give us the leverage to get the siting of these centers in our communities.

We pledge in turn to work with providers on standards of care and evaluation and to bring substance abuse treatment into the mainstream of health care and medical services. There is a great deal that can be done, and I think that Mr. Lucas and Mr. Williams were good evidence of exactly how much knowledge there is out there of what needs to be done. We simply do not have the resources.

Thank you very much.

[The prepared statement of Dr. Coye follows:]

## PREPARED STATEMENT OF MOLLY JOEL COYE, M.D., M.P.H.

Mr. Chairman and members of the Committee:

My name is Molly Joel Coye. I am the New Jersey State Commissioner of Health. Thank you for the opportunity to appear before you today to address the drug abuse treatment and service delivery needs from my perspective in New Jersey, the most densely populated State in the Nation.

In the brief time I have, let me offer evidence that the drug abuse situation is very serious and, at this time, major funding infusion would make a difference because treatment does work. Because of the complex nature of this issue and the short time I have, my testimony will be presented in a very abbreviated form but reflects numerous critical issues. I would be happy to provide expansion on any of the issues I discuss at a later time.

At least 50,000 New Jerseyans are intravenous drug users (IVDU) needing immediate care, and State and federal funding currently at our disposal can serve only 15-20% of those in need. In addition to the 50,000 IVDUs and probably 150,000 cocaine users, we only have 5,700 publicly funded treatment slots. These slots can only provide care for approximately 12,000 people during the course of the year. The lack of funding for drug abuse is not only killing the drug abuser and his family, but is undermining our ability to control AIDS and improve maternal and infant health. In New Jersey, we also have approximately 7,000 AIDS cases and we estimate 70,000 people are infected with the virus. Approximately

60% of these people have been infected by needle sharing or having sex with a needle sharer, which further exacerbates the inadequate funding of drug abuse services for New Jersey residents. In the past several years, we have seen general improvement in reducing infant mortality, and this success if being rapidly eroded because more pregnant women are using crack and cocaine, and the effects on the baby, if it survives, are devastating. As a example, one of our prenatal clinics reports 20% of its patients have illegal drugs in their urine. Mothers, who are addicted to crack and/or cocaine like all other addicted individuals, are preoccupied by the need to fuel their addiction and, therefore, provide little or no care for their infants and children. As an example, some social workers report finding babies lying under beds while the mother is lying on the sofa, high on crack.

New Jersey's Governor Thomas H. Kean has spearheaded a "Blueprint for a Drug-Free New Jersey" and, as a result, New Jersey's schools are beginning to deal seriously with the drug problem and, in the first year of operation, specialized school Substance Abuse Counselors have identified 7,000 students with drug problems serious enough to require referral during one school year. We anticipate that once every school district has a trained Substance Abuse Counselor, the number of students referred for treatment services could quadruple. You've also heard, I am sure, that New Jersey neighborhoods are literally barricading their streets from drug abuse, and they're begging for help, yet we don't have enough treatment to help those addicted resist the pushers who get through the barricades.

There should be no skepticism as to whether drug abuse treatment works. It does work. The federal government itself has funded studies which show that drug treatment is effective in controlling and reducing the use of illegal drugs, increasing the number of drug abusers who can remain employed while in treatment and decreasing their criminal behavior while they are in treatment. One study I command to your attention is TOPS. TOPS is the largest and most comprehensive national study of treatment effectiveness-it involved 10,000 clients in 37 programs across the nation, and demonstrated that treatment is effective in all three major modalities.

We must understand, however, that drug abuse is a chronic illness. As such, we must expect individuals to need multiple detoxifications and multiple courses of treatment to control their disease. It may never be fully cured as is the case with most chronic disease. Because it is a chronic disease about which we are still learning much, we can expect that different treatments will work better for different individuals such as methadone maintenance which focuses on one aspect of the disease while proper psychological counseling focuses on other aspects of the disease.

Nor should we be skeptical that drug abusers want to receive care. The evidence is overwhelming that drug abusers want care but can't get it because there are insufficient places to receive care and the cost exceeds that they can pay. Many clients in New Jersey are forced to pay for a portion of their treatment services because of inadequate funding, and we have definite evidence that charging some clients a fee often prevents them

from seeking services. The demand for treatment services in New Jersey far exceeds our capacity to respond. Even though we have increased both the adult and juvenile treatment slots over several years, each time a slot opens it is immediately filled and people are turned away. Particularly young people needing residential services must wait months to get into care. During 1986-1988, we offered a coupon redemption program targeted at hard core users who had not been in treatment for one year. Coupons were distributed to addicts by street workers and 85% of the several thousand coupons distributed were redeemed for drug detoxification services, 45% of those redeeming the coupons had never been in treatment before. This program was a great success, however, it further placed a demand on the treatment system that we can no longer respond to. As effective as the coupon reduction program was in ferreting out hard core IVDUs and getting them into treatment, we had to disband the program because we did not have the treatment capacity to continue to provide services. We know that many of these people drifted back to the streets because neither they nor we had enough money to keep them in treatment after detoxification.

This Spring we launched a behavioral study for IVDUs on ways to protect themselves and their sex partners from transmission of the HIV virus. A free detoxification was offered and in the first month, in one neighborhood in one city, 182 people came in off the street and all wanted to be enrolled into treatment. This behavioral study program has already identified 300 people and over 60% are HIV positive. The number of people identified and the percentage HIV positive are astounding. The people who

aren't in treatment have higher HIV rates than those who are, and we're already facing the fact that there's not enough room or money to keep these 300 in care. I ask you the question that is asked of me, "Where are they to go?"

Under the recently enacted ADAMHA federal "Drug Abuse Treatment Waiting List Reduction Grant Program," 37 drug abuse providers applied for federal funding through our Department of Health, as the lead umbrella agency. 3,260 people have been documented in our application as being on a "waiting list" for treatment services. Our application requests approximately $4,000,000 of the $75,000,000 available nationally and, even if New Jersey is successful in receiving these funds, the Drug Abuse Treatment Waiting List Reduction Grant Program will be only funded for one fiscal year. I ask you what New Jersey is to do after the funds run out, and we have identified and provided treatment services to these 3,260 IVDUs? Needless to say, I repeat again, adequate, long-term funding to provide treatment on demand is most critical for us in New Jersey. Federal funding for drug abuse treatment must be doubled if not tripled for residential, outpatient methadone maintenance and outpatient drug free to make an impact.

Drug abuse treatment services are the only area in the health care delivery system that are so severely rationed for the middle class, the poor, and the medically needy.

Unfortunately, drug abuse funding has been and will continue to rely heavily on public State and federal revenues until such time as private insurers cover this service. Even then, financing indigent and medically needy patients will still be needed. Many Medicaid programs do not cover the single male and, therefore, the largest group of indigent patients have no source of care except that available through direct grants. This federal entitlement funding shortcoming must be addressed by Congressional leaders. The funding must be stable, long-term - not a perpetuation of the current one shot quick fixes like the waiting list effort.

Up to this point, I have been talking exclusively about the need for funding to provide care and services to the drug abuser and, unfortunately in New Jersey and in many other states, the facilities in which care is provided are totally inadequate, over-taxed, and need major expansion. Therefore, the capital construction and renovation projects are a critical component for the expansion of our drug treatment delivery system. It is unconscionable for us to continue to "squeeze" clients into treatment facilities that are "bulging at the seams" where adequate counseling and services cannot be provided. I recommend specific funding streams be identified for these capital needs. While I am on the subject of capital, we need federal leadership in helping to overcome the N.I.M.B.Y. (not in my back yard) syndrome. Even with funding we cannot get care to addicts until we impress on our communities the importance of permitting health services to be established in their town.

Unfortunately, because of inadequate fiscal resources, many drug treatment programs do not have the capability to provide intensified "relapse" care services and high intensity aftercare services that most clients required for complete recovery.

Again I wish to thank you for the opportunity to speak with you today and, as the New Jersey State Commissioner of Health, I pledge my support to work with you in a concerted effort aimed at once and for all providing adequate resources in order that New Jersey and all other states will have the capacity to truly provide services to people in need on demand. Anything short of this goal, in my opinion, will result in a continuation of a patchwork, inadequate, response to this National scourge.

The CHAIRMAN. It is a very distressing and disturbing statement about what the real world is about in New Jersey, and I think it is, in one degree or another, repeated in other areas.

Let me ask just one thing, because I know you have to go. That is, have you experimented at all with what you can do with addicts who want treatment but you cannot provide it? Do you have sort of a follow-on program? That has been talked about, and maybe you can describe it.

Dr. COYE. OK. You probably know that the FDA just finally released the new regulations that allow the use of methadone without the usual counselor ratio so that you could on an interim basis give methadone to clients who come in seeking treatment when you do not have the resources for full treatment. This is very controversial, as I am sure you know.

We supported that, and I feel strongly that, as a physician as well as a health commissioner, if an addict comes in a door of a treatment center and wants that day to stop being addicted, because this is the kind of thing you have got to catch them on the day when they make that decision, if they come in and they are willing to go, and desperate to go into treatment and we do not have the resources for full treatment, that to be able to maintain them on methadone for whatever number of months it takes to clear the waiting list is definitely second choice, definitely not optimal, but it is something that would be a great improvement.

The CHAIRMAN. Let me ask another question. We spend resources to treat about 15 percent of the addicts, it is estimated. What is your sense about the numbers who would come into treatment if it were available? Is it 30 percent or 40 percent?

Dr. COYE. I think it is higher than the NIDA estimate, which is roughly 50 to 60 percent. Those estimates were made before the full force of the HIV-infection epidemic began to be seen. In our communities when everybody who is injecting drugs knows somebody else who has got slim disease, who is wasting away of AIDS, there is probably a much higher proportion of people who, with minimal outreach, would come in to treatment. So I would say that in the first—I mean, it is more a capacity problem. We need more sites if we are going to be able to do it.

One of the things we are experimenting with is trying to move that back into hospitals and clinics so that you do not have to have separate independent drug treatment centers partly because so many of the addicts are sick now with AIDS that you need to integrate the health care with the drug treatment.

Senator KENNEDY. Tuberculosis.

Dr. COYE. Yes.

Senator KENNEDY. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Dr. Coye. Those were certainly interesting comments.

I would like to ask, when you mentioned Mr. Lucas and Mr. Williams in their programs, how much does New Jersey do with coordination of all of the different efforts that are out there? Do you try, as commissioner and as the commission, to pull those efforts together?

Dr. COYE. Very much so. It is interesting because I think that each State goes at a different stage through some of this, and in

our State it was about 2 or 3 years ago that Governor Kean brought forward the blueprint for our attack on crime and drug problems in New Jersey.

As a result of that, we are now forming a statewide coordinating council. In the past it really was the Health Department that performed most of those functions, and we were very successful with human services and education. But there really was not enough integration with corrections and criminal justice and the other areas. And I think that you have the same problem in the Federal Government where you have 17 or 18 different agencies with responsibility. I am pleased by Mr. Bennett's efforts to pull these together, but I am distressed that public help and treatment has not been included as a stronger role so far. Maybe he plans to bring that forward.

Senator KASSEBAUM. Those are very, very pertinent comments. I am impressed. I was interested in your last comment when you were answering Senator Kennedy regarding the use of the hospitals. Am I gathering from that, that you see the ability to use, perhaps, hospitals where there are some empty beds and the facility could be used in some way for long-term treatment?

Dr. COYE. Not only for detoxification and inpatient treatment, but also for the outpatient clinic setting, because it is a lot easier to open another clinic, a drug treatment clinic within a hospital setting than it is to site it in the community. And so especially for hospitals that are providing medical care for addicts already, with a relatively small amount of renovation money, we may be able to do something both inpatient and outpatient.

Senator KASSEBAUM. Are you doing that in New Jersey now?

Dr. COYE. Yes, we are. We are doing it with State money now, but there is also a good HRSA/NIDA, very small, but a good seed money program that they have done for the first time this year. We are encouraged. There are some signs of beginning integration of effort.

Senator KASSEBAUM. That is impressive. One last question.

How do you feel about the distribution of needles to drug abusers?

Dr. COYE. I am opposed to it. I think that unfortunately when you have infection rates as high as 50 or 60 percents in most of the areas where AIDS is a real problem, you wind up having—it is like Russian roulette. It is a 50 percent chance if you shoot up that you are going to be infected. And almost all of the addicts who report that they have tried to start using bleach or try to only use a clean needle, then go on to say that they share their cooker or their cotton with somebody else, which is a part of "the works," it is a part of the way you inject the drugs. So the effect, except apparently in some communities where maybe you have people who are wealthy enough addicts that they can sort of be at home and have a steady source of the drug, the effect of it is that it does not change the exposure of the people very much.

I think it is sad, that it is an indication of how much people care about—how scared they are. They want to get out of AIDS so they will try to go for a clean needle, and they will pay an additional $3 or $4 in New York City or in Newark to get a clean needle on the streets that is not even clean. And then even if it were clean, they

share the rest of their works with somebody else or with 10 other people. So I think it is a little bit illusory.

I support Commissioner Joseph's experiment in New York City. I think it would be good to know the answer.

Senator KENNEDY. Senator Coats.

Senator COATS. Thank you, Mr. Chairman.

I appreciate your testimony, Dr. Coye. I am reading now some testimony of Mr. Hatcher and Major Hughes because I cannot stay to hear you, but it is good stuff, and I am very interested in it, and I regret that I have other commitments that I have to go to. But thank you for your testimony.

The CHAIRMAN. Thank you, Dr. Coye, very, very much.

Dr. COYE. Thank you for the opportunity to speak early.

The CHAIRMAN. It has been very, very helpful to us.

Major Hughes.

**STATEMENTS OF MAJOR DOUG HUGHES, DIRECTOR, OFFICE OF SUBSTANCE ABUSE CONTROL FOR DADE COUNTY, MIAMI, FL, AND DAVID HATCHER, DRUG TREATMENT SPECIALIST AND PROBATION OFFICER, TOPEKA, KS**

Major HUGHES. Yes. Thank you, Senators.

First, I would like to comment about law enforcement. I have been in law enforcement for 24 years, and I have worked in some of the difficult areas of Manhattan, Harlem, Bedford-Stuyvesant, the South Bronx area, the Hells Kitchen area. I was in Liberty City in Dade for the rest of my career, and I was the commander of a crisis intervention unit, also the commander of Liberty City during the 2 years after the civil disturbance there.

I also wrote the civil disturbance plan that was used for Dade County.

In addition to that, I have been involved in the homicide investigation, community relations, and I was Dade County's first Drug Czar and then the first Drug Czar for the State of Florida. So all of my background is law enforcement, high risk poor communities, and most recently drug systems.

I would like to comment on—first make three statements, one, my belief is that aggressive law enforcement is extremely important in this effort against drugs. But it is not and will never be more than a holding action, an action to stabilize our society while we get healthier through the implementation of health care, human services, treatment, prevention, and education programs. Those, unfortunately, have not been given the priority so they have not kept pace with law enforcement.

We have 2 choices. If we continue to build prisons, we will never see an end to the problem. We have to focus on the building of people.

The next position is we are not talking about Drug War 1989. We are talking about Operation 2000. If we look just at what we have done in the cigarette area and the damage, the health problems of our country, and the time it has taken to see a reduction, we start to see a comparison between what a real drug war means in terms of commitment. My biggest challenge in trying to address this issue to the political environment and to the corporate environment is

this is not a 12-month objective with an 18-month implementation plan. This is a decade that we are talking about, at least.

My second, my last comment is that we do not have a drug problem in America. We have a people problem in America. As we continue to combat the drug, we are merely addressing the symptom. We have to address the cause that contributes to that symptom, and that again is dealing with the human issues in our society.

Dr. Inciardi, a well known researcher for many years, is the director of Criminal Justice Programs at the University of Delaware. He just finished a shocking study in Miami, in Dade County. With 254 drug and crime involved youth, he found that they used alcohol regularly before the age of nine, marijuana regularly before the age of 10, cocaine regularly by age of 12, and crack by age 13. They committed over 223,000 crimes a year or 880 crimes each, including 9,000 major felonies, and 22,000 acts of prostitution, 100 percent of them were involved in prostitution, and the average age, the mean age was 14.7.

They were regularly engaged in criminal activity, regularly engaged before the age of 12. They were getting caught once for every 555 crimes that they committed.

So my point is, dealing with the cartels, dealing with the distribution networks in the country are extremely important, but we must deal with the youth of our society if we are going to make a difference.

Dr. Curry, William Curry, he wrote a great book talking about confronting crime in America, and he summarized it very eloquently, I think, and simply. He said, "We have to stop dealing with the overflowing tub and mopping the floor and turn off the faucet, the source of the drug problems in the country." And those again involves getting back to the people issues in America.

Two comments that are particularly important to me to stay within the time context, one, cocaine babies. We are seeing an explosion of the problem of cocaine babies. But what America is not realizing is what they represent to our society in terms of demands and in terms of challenges for our health care systems, our educational systems, our criminal justice systems, and our corporate world who must deal with the needs of training individuals who are impaired from birth.

The next is our poor communities. We are clearly seeing the division in our society to dual societies. I have been in 10 civil disturbances. I spent many years in the Liberty City area converting the problems to strong relationships between community and government, particularly police. Law enforcement can only delay what many professionals in our country, in fact a Rand think tank project to be disturbances in America in the next decade. Law enforcement can only delay that rupture, they cannot prevent it.

Addressing human services can avert that eruption in our country.

My recommendations, first, do not look for anything dramatic. You have already had appropriation recommendations of $2.8 billion in the last Congress, and it was the most insightful legislation I have ever seen, and it got headlines across America, and I supported it. It was only funded to the tune of $1 billion, a little more than a third, and most of that was law enforcement. I come from

law enforcement. I support it, but without balance, there will be no progress.

Second, we must have a balance at least a 50/50 split in our funding supporting demand and supporting supply. Supply gives us headlines and media gratification. It plays well to the media and the public buys it. Supply will never be the answer. Demand is the answer, but we are not funding it.

Third, treatment. We have R&D the backbone of the corporate world, R&D the backbone of the military industry in our country. Why do we look at treatment as a failure when it is only 30 years old, when it is our most recent social effort, and it is certainly not a science. Yet, we criticize it for not being perfect. We must look at treatment as development. We must look at treatment as research because we are dealing with changing populations, we are dealing with changing drugs of choice in America. Unless we look at it as developmental effort, we will see no progress again.

Fourth, target poor communities, and particularly public housing. I commend some of the comments that have been made recently by Secretary of HUD about public housing communities. That is my background. Unless we develop healthy individuals, healthy families, healthy communities, and then States and Nations, again, no progress.

In the effort to recover and develop our poor communities in this country, years of work are being wiped out in months by the infestation of crack cocaine. We have to get in those communities and provide services and stabilize them. Law enforcement is the first effort. Recovery and making those healthy communities is a long-term success. Evaluate, and evaluate, and evaluate. We have shotgun programs. We do not evaluate them. We do not know how they work. We must evaluate them. Measure success by recovering individuals, recovering communities by recidivism reduction, by arrest reduction, not by tonnage of seizures and by arrest statistics.

Fifth, drugs are a symptom of an unhealthy society. They are not the problem.

Last, all of the things we have talked about, and I bring a report to submit for your record that was prepared this year to our governor, and the first 20 pages or so, talk about overall strategy, supply and demand. We will never be successful in this country, including if we implement the full range of strategies we are talking about, until we have a sustained commitment by the American media, because the America media molds the opinion of American society.

I could talk more, but my time is up. Thank you.

The CHAIRMAN. Thank you very much. Mr. Hatcher.

Mr. HATCHER. My name is David Hatcher. I became a U.S. Probation Officer in February 1974. As senior officer and drug specialist for the district of Kansas, I thank you for this opportunity to appear.

I prepared a statement which has been entered into the record. I will not repeat that statement, but I would like to take the opportunity to make some points from that statement.

I would like to point out that we deal with a population that is not volunteering to receive treatment. Individuals that we deal with are persons who have been convicted of Federal offenses, or who have been charged with Federal offenses, who we have identi-

fied as having histories of drug use, and whom we have required to participate in a drug treatment program.

Some of the testimony you have heard today, and indeed my own early training in graduate school, has stated that for treatment to be effective, that a client must have hit bottom, that a client must want to be treated, that a client must want to be helped.

As an arm of the United States courts, we are a law enforcement agency. We do not have the luxury of treating or dealing only with those individuals who have decided that they want to be helped. Our primary obligation by statute is protection of the public. In order to meet that requirement, we must identify individuals who have a history of drug use, and we must respond and deal with their propensity for return or their continuation of that drug use.

As you are already aware, many of these individuals who use drugs will, in fact, commit new criminal behavior. Our job is to try to prevent that criminal behavior.

I would like to make some brief points additionally in terms of the problems that we have in dealing with this population.

First of all, our experience in this regard has been that simple punitive action is ineffective by itself. We can collect urine specimens from clients, we can identify drug use, and we can incarcerate them. That is easy to do. That is also very expensive. We do not have the room. We do not have the capability of doing that.

Second, we have found that simply referring a client to a community based voluntary treatment program is also ineffective, at least for our clients. We have a high rate of no show, of program failure, of lack of participation, and ultimately when we pursued that avenue of treatment, we found that many of these clients would revert to again new criminal behavior and would ultimately be incarcerated in prison again. So we had a cycle, continuing cycle of drug use, of new criminal behavior and incarceration.

Now, given the fact that we are dealing with clients who are not volunteering to be treated, who in many cases would prefer to continue use of drugs, and given the fact that we have a mandate to protect the public and to deal with these clients, and again, considering our previous experience with regards to these programs, both punitive and rehabilitation, what we have done in the district of Kansas is to finally adopt a comprehensive approach, which we find to be reasonably effective.

The approach, first, mandates treatment, and we find that we can mandate treatment and that it can be effective. Second, the approach utilizes a punitive consequence for program failure. It is a highly structured program. Violation of participation in that program will result in some negative consequence, but third, we try to provide the clients with the tools that they need to make long-term, significant behavioral changes.

This approach marrying or unifying the possibly opposing views of treatment and punishment we find to be effective. It seems to be working. I think we could be doing more than what we are doing. I think it could be more effective, but I have no doubt that the approach that we are utilizing at the present time is having some very significant results and is certainly more successful than our previous experience utilizing either a purely punitive approach or a purely rehabilitative approach.

We contract for these services. We developed our own program. We have developed a precise program involving a number of services, which I will briefly mention. We contract into the private sector to provide these services. But then rather than simply referring the client and waiting for reports back as to how the client is doing, we closely monitor the program. We train the contractors as to our program philosophy and our treatment philosophy. We interact with the contracting agencies on a frequent basis, and we try to formulate a team approach whereby the probation or pretrial service officer has some specific obligations and specific responsibilities, and the contractor has separate responsibilities and obligations.

We find this treatment approach, that this hands-on kind of involvement with the program is certainly more effective than referring the client to some community based program.

The services that we provide in this contract include urine surveillance, urine surveillance occurs usually in a phase one capacity of 6 to 10 urine specimens. They are all surprises—the client finds out that same day if he or she has to provide a urine sample, an observed urine sample that day.

The program is structured. We do not provide clients opportunities to avoid participation in the urine surveillance program. If they have a problem, such as transportation, we may be able to help them financially. If they have a problem with regards to employment, we may be able to alter our schedule to accommodate their employment schedule. But ultimately they have to be there. We simply will not accept excuses for failure to participate in any aspect of the program, but especially in the urine surveillance part of the program.

What we also do, though, is we provide services which include family, individual, and group psychotherapy. We provide services which include psychological and psychiatric evaluations, vocational and work skills assessments, free employment training and job placement. We may provide detoxification services, both within a community based setting as well as within a hospital based setting, inpatient treatment, and long-term residential treatment that may require the client's participation in residential treatment program for up to 9 months. We also provide, when necessary, emergency financial assistance, under strict guidelines, I might add, as well as transportation assistance when appropriate.

These and some other services, which I haven't mentioned, provide the client with the tools that he or she needs to make some significant changes in their behavior. But at the same time we insist upon accountability on the part of the client. We try to teach the client the consequences of behavior, and we insist these consequences be enforced,

That is a brief summary, in effect, of my program. I thank you for the opportunity to advise you of that, and I would be happy to respond to any questions you might have.

[The prepared statement of David Hatcher follows:]

## PREPARED STATEMENT OF DAVID HATCHER

"y name is David Hatcher. I have been employed by the United States Probation Department for the past 15 years, and for the last five years, I have been the Senior Officer and Drug Specialist for the District of Kansas. I am accountable directly to the chief U.S. probation officer and the federal judges sitting in the District of Kansas, as well as to the Probation Division of the Administrative Office of the United States Courts. My current responsibilities include development and adminstration of the drug programs within the District, under the direction of the chief U.S. probation officer. These duties include the monitoring of programs within the District and the training of program staff and other federal probation officers. I have been privileged to provide training on behalf of the Federal Judicial Center and have served on temporary duty assignments here in Washington.

The Probation Division has developed a comprehensive drug treatment program for federal offenders that begin with individuals charged with federal offenses and released under the supervision of the Pre-Trial Services while awaiting trial. Services continue to be available subsequent to conviction, while on supervised release. While offering a structured format for treatment, the Probation Division program allows for individual adaption by Districts so that needs unique to a particular District may be addressed and also to allow development of a program reflective of the philosophies of the federal judges of the District.

The District of Kansas provides a drug treatment program for individuals under federal supervision. The program has evolved over a period of years into a comprehensive approach and reflects experiences we have had with various approaches. The most significant evolution of our philosophy deals with the criteria for effective treatment. As a graduate student in the early 1970s, I was taught that treatment could not be effective unless a client sincerely wants help. As a young, inexperienced probation officer, I can still recall being puzzled by a client who perpetuated a cycle of drug use, incarceration, return to drug use, and so forth. To illustrate this, I would like to give the example of a former client of mine named James. Every Christmas and New Year's season, following release from prison, James would use drugs. My graduate studies had taught me the meaning of terms like anomie and alienation, and I presumed these sociological factors to be relevant to my clients' recidivism, and so I asked James why he reverted to drug use every holiday season. James furthered my education by looking at me with complete puzzlement and proclaimed, "Hey, man, it's party time!"

Drug use may be related to sociological variables and undoubtedly is more likely to occur when personal and social circumstances provide the escape of drug use as an attractive alternative. Some may use drugs because of personal pain, some through peer pressure, and others, such as athletes, who perceive a competitive edge provided by artificial stimulants. Some use drugs simply because they like the "high." Some just make bad decisions.

The U.S. Probation Department is a law enforcement agency, an arm of the U.S. Courts, and part of the Judicial branch of government. Our primary responsibility is protection of the public. We are not allowed the luxury of treating only those clients who request assistance. Our responsibility dictates that we mandate treatment, and that is what we do. We identify persons under supervision who have a history of drug use, and under the authority of the U.S. Courts, these individuals may be ordered into treatment. Participation is mandatory.

This program provides a comprehensive approach to treatment and combines our responsibility to the public as well as to the individual. When a conflict does occur, protection of the public takes priority. These conflicts, surprisingly, are not frequent, and we have found that mandatory treatment, if accomplished appropriately, is effective.

The components of our program include urine surveillance, individual, and family counseling, and may include group counseling. The program also includes the capacity for psychological and psychiatric evaluations and physical examinations. We may require participation in a program of detoxification, inpatient, and residential treatment. We have for the past year provided preemployment training and job placement and have recently entered into a contract for intensive outpatient treatment. When necessary, services may include transportation assistance and emergency financial aid. We have tried a couple of things that haven't worked well and have expanded those that seem to be effective. Some clients don't make it and are incarcerated. Most clients do make it, and of those that don't, most are identified before the onset of new criminal behavior. Of that majority who complete supervision without reverting to drug use, many probably would have reverted had they not been involved with the program. The average annual cost of the program is about one-sixth the cost of incarceration. As you can see, the program is an effective alternative to imprisonment.

In terms of the specific services, these are contracted out to the private sector. Rather than simply pay for a client's attendance in a community-based program, we have formulated our own program and contract out with private individuals or agencies to implement the program. Part of my job is to identify and develop appropriate programs of treatment, identify potential competitors to provide the needed services, and solicit bids.

Subsequent to awarding a contract we monitor the program closely for contract compliance and provide ongoing training and oversight. This program provides a highly structured setting in which the roles of the probation officer and therapist are clearly defined, not only to the contractor but, more importantly, to the client. Services are authorized by a program plan completed by the probation or Pre-Trial Services Officer which identifies the specific service required, including the frequency of that service. Program plans are modified frequently, generally as a result of case staffings between the officer and contractor. Services to a client cannot be refused, nor can a contractor dismiss a client from the program without authorization by the probation officer. Thus, the Pre-Trial Services or Probation Department maintains close control over implementation of all aspects of the program.

As stated earlier, the program is highly structured and participation is mandatory. The contractor does not have the authority to excuse a client from a service. An example would be the urine collection program. Typically, a client will enter the program on Phase I, requiring six to ten unscheduled urinalyses and four hours of therapy per month. The client will be required to telephone every morning except Sunday, to a telephone answering device to learn whether or not he or she is required to submit an observed urine specimen that same day. An effort is made to accommodate the client's schedule, but the client must show up or risk sanctions for violating release conditions. The urine specimen is mailed to a laboratory under contract to the Probation Division. Positive specimens must be confirmed by a separate testing methodology.

Probation officers are provided guidelines as to appropriate consequences for various violations. The consequences range from simply increasing urine surveillance, to inpatient placement or, ultimately, incarceration. Generally, various sanctions, both punitive and treatment-oriented, will be imposed before incarceration is recommended. Factors involved in the decision-making process include the seriousness of the violation and the risk or threat by the client to the public. While the consequences imposed must be reasonable and effective, equally important is the certainty of detection and consequence.

In my experience as a Federal Probation Officer, I find that we generally deal with two categories of drug users--those who can change their behavior to avoid negative consequences and those who will continue to use drugs in spite of the consequences. The former group may include individuals who consistently make bad decisions, as well as those for whom the euphoria of drug use seems an attractive alternative to their inability to manipulate their environment effectively. For these individuals, a tightly structured program of detection and treatment can be highly effective. Counseling may deal with the effects of drug abuse, but frequently will focus on dealing with problem-solving within the everyday environment. Impulse and anger control will be addressed, while some sessions may deal with budgeting, how to get a favorable loan, or even how to ride a bus. Psychotherapy may deal with very abstract issues surrounding control of behavior, but more often, will utilize a pragmatic approach toward coping with daily problems. We insist that a client be accountable for his or her actions, and our ultimate goal is that a client be more productive and happier being drug-free than when using drugs. We feel that this client is more likely to remain drug-free following release from supervision.

A client participating in Phase I of the program, involving six to ten surprise urinalyses per month as well as weekly counseling, is eligible after six months to progression to Phase II of the program, and eventually to Phase III, each step involving a reduction in the rate of uranalysis and counseling. The minimum time of involvement is 12 months, although clients average about 24 months of active program participation. During this process, accountability and responsibility by the client is stressed and required. At the same time, we provide the client with the tools he needs to modify his environment, to enhance his decision-making capabilities, and to achieve impulse control. The probation officer and therapist act together as a treatment team, and while participation by the client is forced, success in the program frequently results in a client's willing participation.

The comprehensive approach used in Kansas employs philosophies of punishment and rehabilitation and mandates participation. We believe that the marriage of these apparently conflicting philosophies compliment each other. Subsequently, punishment without comprehensive treatment or treatment without the threat of punishment will be less effective in achieving permanent modification of behavior.

The CHAIRMAN. Thank you very much.

Let me ask you, Major Hughes, what are some of the programs that have been the most effective in working with some of these troubled youths? We have heard a good deal earlier today from our first panel about different programs being developed. Could you give us any insight on some of those, or perhaps even the names or, to the extent that you can get into, brief descriptions of those that are working most successfully in the areas either of education or in terms of counseling, outside of treatment, and then maybe I will come to that?

Major HUGHES. OK. The primary point is to start as early as possible, and we talked before about the prenatal care. That is a program because those kids who are born to abusing mothers start off with deficits that some never recover with. So I would say the prenatal care for substance abusing women, pregnant women.

Next, we have alpha programs in our schools. The two things you need in the school are, first of all, a curriculum that is age appropriate and culturally appropriate for different populations, but that only gets two-thirds of the kinds, and saves the peripherally at risk kids. One-third of them are already drug involved or are using or coming from substance abusing families. So alpha programs identify those high risk youths, give them a concentration of services to not only support their drug-free life for the future, but to intervene on those problems where they are already having problems.

We find the curriculum that talks about social skills to be more effective. It teaches them to resist peer pressure. It teaches them assertiveness, training in self-personal insight, and it teaches them to deal with reality and not hypotheticals in our society. So I would say the combination of developing skills to cope with the stresses of society, the curriculum that is culturally based and age appropriate, and then the intervention capability within our school system.

There is no institution in America that has the access to children that school systems do, and we just cannot replace them with anything else. We should use the family. We do not have the consistent access or support from family environments. So the first public institution is the schools, I am sorry to say starting early and referring to appropriate programs. Schools should not treat. They should identify and refer, and then have reentry programs to bring the children back after treatment.

The CHAIRMAN. How many of the schools in Florida now have that program?

Major HUGHES. We have 700 elementary schools and 17 alpha programs.

The CHAIRMAN. But that is an expanding program?

Major HUGHES. Very slowly, yes, sir. We are putting attention to it. We are a growing State and a multicultural State. So our educational system is under great strain.

The CHAIRMAN. Are the limitations just on the expansion of those resources?

Major HUGHES. Yes, sir.

The CHAIRMAN. The pattern, which you have described, could be readily available to schools themselves if they had both the resources and the educational services.

Major HUGHES. Yes, sir. The models are pretty well established.

The CHAIRMAN. Mr. Hatcher, earlier in the opening of the hearing I pointed out that only 11 percent of our Federal prisoners get any kind of treatment. I guess it is about 20 percent in the State prisons. You have outlined some of the ideas which I think are important for us to hear about and pay attention to. How important is it that you develop effective substance abuse programs in Federal prisons?

Mr. HATCHER. I think that it is extremely important. At the present time, the probation service is able to provide services beginning at the pretrial services stage, when a person is first charged with criminal behavior. We can also provide that service if a client is placed on probation, and again when they are released from custody.

I am not in a good position to talk at length in terms of the programs that are available within the Bureau of Prisons. I do have some knowledge of that, of course, and it appears that there is a gap in terms of our treatment process, in my opinion, with regards to the continuation of the services which may begin at the pretrial services stage, and then are resumed again after release from prison. I think a better coordination between the agencies would be more effective.

The CHAIRMAN. It is probably as much a political problem because the people, I would imagine, would say if there are scarce resources, let us try and focus in, like Dr. Coye has pointed out, to people who are not in prison. So that can have a ring—I would think that has a ring politically rather than the people that are behind bars.

But I imagine both of you as law enforcement people, if you are going to try and deal with the crime and recidivism, it has to have some importance and some priority, does it not?

Mr. HATCHER. Absolutely, Mr. Chairman.

Major HUGHES. Dr. Doug Lipton of, I think it is called NDRI in New York, has done longitudinal research on the effects of drug treatment and there are dramatic differences in the crime rate recidivism and the length before return of those who had good drug treatment and those who did not. So it is a very strong component of the effort, but it is hard to sell. It is easier to build beds than treatment.

The CHAIRMAN. We will look through that study. It seems to me to be enormously important.

Mr. HATCHER. He offers magnificent testimony and evidence from a scientific empirical view.

The CHAIRMAN. Do you have any other references? You are going to keep my staff very busy in August reading through these reports. I have been adding to my own reading list as I have been hearing you read these off. They certainly are materials which we ought to familiarize ourselves with, and I certainly will.

Senator Kassebaum.

Senator KASSEBAUM. I would just like to follow through, Mr. Hatcher, in your response to the gap between what you do as a probation officer and the programs that you are overseeing, and that that program is undertaken while they are incarcerated. What suggestions do you have to improve that coordination? I assume that is

not just a question of funding. That really is somewhat a question of commitment.

Mr. HATCHER. Senator, obviously funding has to be part of the issue. I think with adequate resources I think that there can be greater coordination between the Bureau of Prisons, who are in the Executive Branch of the Government, and the Probation Division in the Judicial Branch of Government with regards to the actual program philosophies. I am aware that the Bureau of Prisons is enhancing their treatment programs presently, and making some strong efforts to make more programs available to more inmates.

Under the present sentencing provisions of the Sentencing Commission and other statutes, a client's release on parole is not generally affected or release, unsupervised release is not generally affected by the participation in a program. The philosophy thus is to make the treatment programs voluntary. There is no incentive on the part of inmates to participate in the programs, unless again they simply desire to get help.

Our experience is that we can be very effective in mandating that treatment. If the Bureau of Prisons were to do that, of course, it would utilize a significant portion of their available resources.

Senator KASSEBAUM. Do you meet on a regular basis with prison treatment officers?

Mr. HATCHER. Well, I do not. I know that there is communication between Mr. Chamlee, who is director of the Probation Division, and some appropriate representatives in the Bureau of Prisons.

Senator KASSEBAUM. You mentioned in your testimony that the cost of the program is one-sixth that of incarceration.

Is your program, do you feel, a viable cost effective alternative to incarceration?

Mr. HATCHER. I have no doubt that it is cost effective, Senator. To give some specifics, we average, on an annual basis, an expenditure of about $2,300 per client, which may seem to be a significant amount of money. But I would like to point out that, first of all, we target participation in the program at that level for those individuals who seem to be gaining some benefit from it, but also for those individuals who represent a threat to the public.

We are not a social service agency. If we have a client who seems to be benefiting from treatment, but who does not represent a threat to the public in our judgment, we would generally channel those resources away from that individual toward the client who, in fact, is. So that when we spend that amount of money on a client, we are talking about an individual who very probably would resort to criminal activity and subsequently incarceration were they not involved in the program.

The majority of the people that we deal with at that level, the majority of our clients refrain from drug use, and refrain from new criminal behavior. Or if they do not, we identify onset of that kind of activity frequently in most cases before a resumption of significant criminal activity.

The cost of incarceration on an average basis is over $14,000 annually. Obviously if a significant portion, the majority of our clients refrain from the kind of behavior that is going to result in an incarceration, it is very easy to pay for the program.

Second, of course, clients who do resort to criminal activity, frequently receive longer sentences. They may be sentenced as a habitual criminal by the State, for example, and the cost of that incarceration is thus more significant, even than those whom we revoke as a result of drug use and subsequently come in. I think it is a significant cost savings and I have no doubt that the humanitarian issues involved also contribute significantly to the effectiveness and usefulness of the program.

Senator KASSEBAUM. Major Hughes, you have really been in the front line for quite a while.

Major HUGHES. I am only 29.

Senator KASSEBAUM. Well, then in the major battles, and you must feel much older than that on occasion.

I totally agree with your comments on law enforcement and the importance of keeping up with the other facets of education, health care that must be a part of the total solution, the total picture. But I also wonder if we have really tried to use law enforcement effectively, and this goes mostly to funds. I have little patience, frankly, with offenders who are just part of a revolving door. We are doing a disservice to them, we are doing a disservice to the whole community, and yet we have not had the resources to provide the personnel, to provide the space, I think, in which—this sort of flies in the face of incarceration and treatment—I think that maybe the two go hand in hand if they can be again done in such a way that you are utilizing constructively the time that they are incarcerated.

Major HUGHES. I agree with you completely. We have a captive audience that have to address better than we have been.

I would like to add that to deal with the drug problem in America effectively, I refer you to page 17 of our Florida Report to the Governor, and it talks about a range, again from the prevention through to drug trafficking in prisons. The problem, as I see it, is that we support and we hype and we fund what becomes popular, what is currently seen as the answer instead of looking at a continuum that stresses the range of initiatives that we must have and the term of commitment that we must have. So law enforcement continues to get the attention, but what it does is overload the system.

My analogy before is the law enforcement is a large vacuum that feeds into a small bag. Law enforcement has lots of people we have no business dealing with, but we have no place else to put them. If we had the support systems around the law enforcement effort, then law enforcement could serve as a funnel to bring in people with problems and people causing society problems and feed them into systems other than prisons that could deal better with their problems and not have them return. So your effort, your concern about prisons and treatment is very much on target, and it is one of the examples of the range we have to improve.

Mr. HATCHER. Senator, if I could respond, too.

The essence of the effectiveness of our program is that the majority of our clients are capable of a change of behavior. In my opinion we deal with two groups of clients, those who are going to continue to use drugs, regardless of the consequences, those are the ones that we identify as addicts, and second, of course, we deal

with those who are capable of changing their behavior and will change their behavior to avoid consequences.

The effectiveness of any treatment program or law enforcement program I think has to utilize an assurance of consequences which have to be punitive in nature, but can also take into consideration the fact that if we do not provide the clients, these individuals with the tools for change, that they are not going to change that behavior.

We have to assure detection of illegal behavior and drug use, and we have to assure consequences of that. The graduation of these consequences is based upon our perception of the threat of the client to the welfare of the community as well, obviously, as to the significance of the particular violation. It does not provide a program in lieu of incarceration that, in fact, utilizes the threat, if you will, of punishment and incarceration as an important and significant adjunct to the effectiveness of the program.

The CHAIRMAN. Just on another issue, Major Hughes, and that is these mandatory sentences.

We have just had a report at our Boston Bar Association that stated the requirements for the arrests that they had last year—7,000 arrests just in Boston that were related to crimes with mandatory minimum—are just cluttering their system and really at an enormous burden in terms of processing and getting at the target. I do not know what your experience in your State is. That is something of interest for someone who has been interested in reform of the sentencing provisions which we passed at the Federal level. I can just see any bill coming down—we have I think in the bill we passed last year a mandatory 5-year jail sentence for the second conviction of, I think 2 ounces of cocaine. There is not enough rooms in this building to enforce that within three blocks of here, three or four blocks of here, and yet to try to take that thing on politically is going to take a little time in terms of trying to deal with the issue.

But do you have any guidance on that as a law enforcement person for us?

Major HUGHES. Yes. Talking about cracking down on drugs and tough law enforcement and using minimum mandatory sentence rhetoric is only cheap publicity because unless you fund the system's particular jail system, they do not mean anything.

We had tremendous pressure in our legislative session, which just finished in June, for a range of get tough policies and minimum mandatories, and the only one that we supported, the Governor and the Drug Policy Task Force that I chair, was the 3-year minimum mandatory around the school zones, because we could absorb that based on the fiscal study that we did. All of the others, we could not possibly absorb.

And what happens is two things, first, you overload the criminal justice system and, therefore, as you force new people in, you force others out, not selectively, and second, you wind up having a system that you just cannot enforce in court so the judges allow them to plea to lesser sentences. And those are the ultimate results of programs that promote minimum mandatories with no cost for prison expansion. It will never be more than that either.

The CHAIRMAN. Thank you.

Senator KASSEBAUM. Just a follow on to that.

Dr. Coye mentioned using some hospitals that had perhaps space for treatment.

Major HUGHES. We have explored that. It is too expensive.

Senator KASSEBAUM. Oh, is that right?

Major HUGHES. The problems in our society today is the working poor who cannot afford treatment and the indigents who definitely cannot afford treatment. So the hospital beds are filled at about 70 percent of capacity, whereas the indigent population beds and the working poor beds are over 100 percent of capacity. So what we have to do is look to the expansion there. If you approach a hospital and say, give us a treatment bed for $50 a day, they will say, I'm sorry.

So for those who can afford treatment, hospital bed expansion is very valuable. That is not where our greatest problem is today.

The CHAIRMAN. I saw just in looking through your report, you point out in the private hospitals only about 70 percent of the beds are filled in Florida.

Major HUGHES. Yes, sir.

The CHAIRMAN. But there are vast needs in terms of the public hospitals.

I had a chance to visit the outpatient department at D.C. General Hospital last week where they are doing outpatient treatment. One of the things that is driving that back is the citing problem: The difficulty to get citing.

As Dr. Coye pointed out, they say it is virtually impossible. You think if a prison is bad, try to get treatment, particularly for HIV and those that are involved in that whole process, and that makes it extraordinary. You get the other kinds of health components because of the other health related diseases, for example, tuberculosis and others that can be treated. But a lot of what is driving associations with these hospitals is the fact that they cannot get the siting.

Major HUGHES. There are two issues there. Again, long-term built in, a percentage of facilities for drug treatment programs in the master plan of developing areas so you have buffer zones and good planning. That is another decade plan. I'm sorry, the second one just evades me now.

The CHAIRMAN. Well, if you have some insight on how to develop the citings, because I think we are going to have a tremendous problem with that down the road, please let us know.

OK. We will be calling on you again and again, I imagine, not only in the next 10 years. That was a very interesting presentation.

Thank you both very much.

The CHAIRMAN. Our next panel consists of two students who are involved in drug prevention programs in their schools and communities. Shannon Jones, a junior at Olney High School in Philadelphia, is involved with the Rites of Passage Peer Counseling Program as both a patient and a peer counselor. Accompanying Ms. Jones is Ann Zembroski, a program coordinator for a drug and alcohol abuse program at the Philadelphia public schools.

And we also have Keema McAdoo, a senior at the Jeremiah Burke High School in Boston, Massachusetts, and she is a peer counselor at a high school and in the community church. She is ac-

companied by Marianne Lee, deputy director of the Massachusetts Governor's Alliance Against Drugs.

I thank all of you for being here and look forward to statements by the two students.

Shannon, we look forward to hearing from you. We know you have a very interesting story to tell and we are enormously impressed with what you have been doing yourself and also for others. And we hope that you might share that with us this morning.

**STATEMENTS OF SHANNON JONES, STUDENT, OLNEY HIGH SCHOOL, PHILADELPHIA, PA, ACCOMPANIED BY ANN ZEMBROSKI, PROGRAM COORDINATOR FOR A DRUG AND ALCOHOL ABUSE PROGRAM, PHILADELPHIA, PA, AND KEEMA MCADOO, STUDENT, JEREMIAH BURKE SCHOOL, DORCHESTER, MA, ACCOMPANIED BY MARIANNE LEE, DEPUTY DIRECTOR, GOVERNOR'S ALLIANCE AGAINST DRUGS**

Ms. JONES. Mr. Chairman, my name is Shannon Jones, and I am 16 years old. I live in the Olney section of Philadelphia with my mother, sister, and aunt. And I will be entering the 11th eleventh grade in September.

In the hopes that my story will help other young people who find themselves in the position I was in 4 years ago, I am happy to have this opportunity to appear before you today in order to share with you my drug and alcohol experiences.

I became involved with alcohol and marijuana when I was 12 years old. At that time I did not feel as though I had any more problems than anyone else my age, and I certainly had no desire to use drugs and alcohol. However, most of my friends were using alcohol and marijuana, and because of the pressure they exerted on me to try these things, and because of my desire to be accepted as part of the crowd, I started using alcohol and marijuana. I would also like to add that using these substances did not make me feel any better about anything.

For 2 years, until the age of 14, I used these substances. I did not stop until I moved to New Jersey to live with my father.

There are two reasons why I stopped drinking alcohol and smoking marijuana. One reason was that these illegal substances were not as readily available to me in New Jersey as they were back home in Philadelphia. The second reason was that I was no longer around my old friends who had influenced me to use drugs in the first place.

For the first time in 2 years, since I was 12, I was free of drugs and alcohol. After I stopped using drugs and alcohol though, I still felt extremely guilty and ashamed about the fact that I had used them, and I desperately wanted and needed someone to talk to about that period of my life. At that time, however, there was no one to whom I could unburden myself.

It was at this point in my life that I moved back to Philadelphia to live with my mother, sister, and aunt, and I worried about moving back to Philadelphia. I was afraid I might start using alcohol and marijuana again, and I did not want to. I knew, however, that the pressure could be such that I might not be able to resist.

I first heard about the Rites of Passage Program from a friend who wanted me to join. She was so positive about this program and that it could help me say no to drugs despite peer pressure, that I decided I would try to find out more about the program.

I met with Mrs. Thelma Seniguar, the drug prevention specialist, who provides counseling services to Olney students who are involved in the Rites of Passage Program. Finally, I had found someone that I could talk to about my involvement with alcohol and marijuana. She was so understanding and supportive that I was able to talk freely to her and unburden myself of the shame and guilt I had pent up and held inside me for the past 4 years. After talking to Mrs. Seniguar, I was anxious to become a part of Rites of Passage.

My involvement with the program began in September of 1988 when I started to attend group sessions and discovered, just by listening, that I was not alone and that many other kids my age had experienced drug and alcohol problems and the feelings of guilt that go with it. I was not put under any pressure to share my story with the rest of the group until I felt ready. I finally decided to share my experiences with the group, and afterwards I felt much better.

In February, I became a peer counselor and have continued in that role to this time in an effort to help others and myself, and I plan to continue being a counselor through my junior and senior years of school.

As a peer counselor, I listen to my peers in the program. We offer each other support, understanding, honesty, trust, and confidentiality.

I want to thank you from the bottom of my heart for allowing me to share my drug and alcohol experiences with you, and thank God for the Rites of Passage Program, which has enabled me and others in my position to successfully say no to drugs.

The CHAIRMAN. Very impressive. I will have some questions for you, Shannon, in a few minutes.

Keema, we are glad to have you here.

Ms. MCADOO. Thank you, Senator.

The CHAIRMAN. I might mention to Senator Kassebaum that Keema has a very active leadership role, not only in here, but she also introduced Reverend Jackson up there in Boston before several tens of thousands of people. As gifted as Reverend Jackson is at speaking, Keema matched him toe-to-toe all the way, and we are glad to have you.

Ms. MCADOO. Thank you, Senator.

My name is Keema McAdoo. I will be a senior at Jeremiah Burke High School in Dorchester, MA. Dorchester is part of the Boston area.

My sophomore year in high school a friend of mine was killed outside of a neighborhood near my school. He was shot and killed. And we later found out that it was because of drugs.

I realized then that I needed to reach out to my friends to help them stay away from drugs. My sophomore year I joined a drug and alcohol peer leadership program. I heard about the peer leadership program from my high school which had drug and alcohol education following the death of my friend.

After 5 weeks of training, I took a hard look at myself and decided that the best way to reach my friends and younger kids was to continue a drug and alcohol free life. Many of the other peer leaders and I worked with younger kids by role-playing different real life situations that they might get into on the streets.

I worked with the Elliott Street Congregational Church, walking the streets and literally recruiting kids to come join our Gym Nights and other activities we may have. A lot of the kids who are members of the Elliott Street Church are my friends, also from school.

At school I am the president of leadership, which joins the drug and alcohol peer leadership groups with the other class officers and leaders in my class. We work together, with support of our advisors and principal, to make our school and community a better place which is free from alcohol and drugs. We know that the work we are doing is reaching out to many teenagers and kids.

The Massachusetts Governor's Alliance Against Drugs administers the Federal drug-free schools funds. All the programs I am involved with receive a portion of this money. And I would also like to add I know deep in my heart that if it was not for the Alliance Against Drugs, that many of these programs would not exist.

In the last 2½ years I have been to 16 funerals of my friends. I had come in contact with them in the church, school, and different organizations. They were killed either taking drugs, by their friends, or the drugs made them trip out so bad that they did something and killed themselves.

I would like to say that it is time for schools, churches, and businesses to invest now instead of having to invest later, much more time and dollars in the future.

I would like you to take what I said to you home and think about it, to help not only myself, Marianne, and Shannon, but help all of us invest in a better future.

Thank you.

The CHAIRMAN. Very good.

Shannon, tell me a little bit about the Rites of Passage. If you find one of your classmates needs a little help, that they might involve themselves in the Rights of Passage, what do you think that you are able to give to that person? What is your organization able to give?

Ms. JONES. I sit down and I talk to them. I explain to them that I was once a patient myself, if you feel as if you need to talk to someone, then you can come down to us at any time. We are there for them and anyone else.

Basically, it is good that they should let it out. Because a lot of peer pressure from their friends encourages them to go back and do it more. And it is not good for them at all. So you can tell when someone—like, if something is wrong. So you help that person. If I see a person, then I just tell them about the Rites of Passage, what it is about, and that if they to come down to talk to us, then just come down.

The CHAIRMAN. Do you find—and maybe Keema could answer this too—that kids would rather talk to their peers or their classmates than to older people? Do you find that to be so? Maybe you could comment on that.

Ms. McADOO. Yes, I found that. A lot of the teenagers would rather—you know, finding out that I am a peer leader, they will come to me, and I will find the resource to get them help. But if I bring another adult and say, okay, would you rather talk to this person, they will say no. They would rather talk to me. You know, or if I can get another teenager, say if they had a serious drug problem, they needed help, and when they go into a program, they do not want to go and talk to an adult, they want to talk to another teenager that, you know, can help them. Because they are afraid that an adult might criticize them or say they should have done better. So they always want to listen to another peer, someone their age.

The CHAIRMAN. Do you enjoy being a peer counselor, Shannon?

Ms. JONES. Yes, I do.

The CHAIRMAN. Does this mean something to you as well?

Ms. JONES. Yes, it means a lot to me. Because when I am in there, you find that you and other students have a lot in common. So you can sit down and share with each other things, what is going on in every day life. And you never know what the both of you are feeling, you know.

It is good that we talk to each other because we have a lot in common. And you also come together as a family while you are there, you know. And it makes you feel good about yourself while you are there.

The CHAIRMAN. Is this available just in the school, Shannon, or is it more in the community? Is it school-based?

Ms. JONES. School-based, yes.

The CHAIRMAN. Are other schools developing these kinds of programs too?

Ms. JONES. There are very few that have them. We would like for a lot of the schools to give them because a lot of schools need them. But there are very few who have them.

Ms. McADOO. In Boston there are 200 high schools that are trained as peer leaders. And what we do at my high school is we like to go out. And professionals will come in and train us, and we go out and do outreach to younger kids, like in 3rd, 4th, 5th grade, and some in the middle school. And what we go out and do is we have real life situations. But with the younger kids, we ask them a question, not a question that will scare them, but a question that will lead into like a role playing. They will automatically come up with their own situations and ask us questions.

So in Boston it is the older kids working with the younger kids also.

The CHAIRMAN. Senator Kassebaum.

Senator Kassebaum. First, I think it is impressive, Shannon, what you have done, and the work that you do, Keema.

I guess I would like to ask, when you see friends who are having a problem, I think particularly young men who are able to make an awful lot of money when they are being used in the drug trade, how do you even reach them?

Ms. JONES. Young men?

Senator KASSEBAUM. Well, or anybody who is making a lot of money as drug runners and so forth. That must be quite a lure to any young person who can make that kind of money.

Ms. JONES. It is very hard. Because them getting the money, that is all that they see. And it is like, well, that is what I want to do, you know. But you still want to try to reach contact with that person. The best thing that you can do is to try to get that person help and talk to them and counsel them if they will come.

You cannot make them do anything, but just, you know, like just talk to them and ask them to come to one of the sessions, or whatever, and just pray for them.

Ms. MCADOO. When you go out recruiting and stuff like that, we see all the drug dealers and everything, and they have their fancy cars and stuff, we have meetings and stuff. We tell them to look around at themselves and look around at their friends. If they started out with 10 friends, by the time we get to them, when they come to one of our meetings, six of them are left.

What we try to make the drug dealers and everybody in Boston realize is that you are doing wrong. And law enforcement or nature will catch up with them. Either you will get your stuff repossessed or the drugs themselves will just make you—you will die, plain and simple.

A lot of them look at the materialistic things. And we like to tell them materialistic things will not last forever. And your body will not hold up forever with, you know, taking drugs and alcohol.

Now, a lot of them do not realize that alcohol is a drug also. It is a major factor too in Boston. They do not realize getting drunk every night, not being able to control your actions by taking alcohol, it is a drug. They think that is something totally different. And we also, you know, want them to know that alcohol is also a drug.

Senator KASSEBAUM. Shannon, when you mentioned that you cannot really make them do it, they have to come to it, to a certain extent, that is the essence of treatment ultimately. But would you think, both of you, that this should be required? If you are talking to somebody who is significantly doing drugs, should it be mandated? Should they have to be in treatment? And this could involve incarceration as treatment.

Ms. JONES. Yes, definitely, they should be treated with this problem that they have, for sure. Because, as she said, you know, they could die. And you try to reach them before it is too late. So we try to talk to them.

And I will come and see Ms. Seniguar and say, well, this person, I know a person, so and so, do you think maybe that you could try to reach her. If I feel as though I am not getting through to that person, I will keep on until that person will come hopefully.

Senator KASSEBAUM. That is quite a responsibility to you.

Ms. MCADOO. I think it should be mandatory, that if a drug dealer is picked up and jailed, that they should go to jail for their crime and before they get out go through some kind of program. I think that probation officers should—automatically if they get picked up for drug trafficking or something like that, they should automatically have to go into a drug program.

Senator KASSEBAUM. Thank you very much.

The CHAIRMAN. I would finally like to thank Ann Zembroski and also Marianne Lee very much for joining us. Just one question for

each, and that is perhaps describing what the situation is in the schools. If you can give us a brief overview on that, please.

Ms. ZEMBROSKI. Senator Kennedy, I have been in the school system in Philadelphia for the last 14 years. And since the crack epidemic, the last 3 or 4 years, we have children who are ages 10, 11, and 12 calling my office trying to get their parents into treatment, if that is any indication of how this situation has changed dramatically.

We have children in our elementary schools, kindergarten, first, second, third graders, who are coming to school who have not eaten in days, who physically are neglected, very often abused, because not only is their mother in most cases on crack, but very often there is no one in the household. It is where the children are now becoming the parents of their parents.

We have instituted eight drug programs. We have grown from one to eight. We know that the school cannot do it alone. We have created partnerships with the community and with the corporate sector to try to continue the drug prevention efforts into the community. We need their support. We have brought in the Philadelphia Police Department. They are working in 42 of our schools every semester with prevention efforts.

One thing that we have learned is that a drug prevention program based in the schools that only offers drug information has a positive effect, but it does not significantly reduce drug taking behavior. What you do have now is a child who will smoke a joint or take a six pack, and he is just more knowledgeable. But what the studies are showing is that when you introduce a peer component, as these girls belong to, that peer component shows them how they can say no, allows them activities where they can practice trying on the saying no behaviors, and still remain popular, not be called a nerd, as the kids will say, avert loneliness.

Because I think if we all can remember back to our adolescent days, loneliness can be very painful. And if taking drugs will bring you into the crowd or allay some of that loneliness, that is a very good option to some of these children. So I think if they can find other ways through the peer group alternative activities, I think we have stumbled upon a really good thing in essence.

The CHAIRMAN. Marianne.

Ms. LEE. Just very briefly, the Massachusetts Governor's Alliance Against Drugs program began even before the first Federal Omnibus Drug Bill. And at that point we raised about $2 million in the private sector. And I think that is a very important key, is that businesses in the private sector are really willing to join with the State and the Federal effort, and they really need to be brought into this strongly.

I just stress again that the K-12 curriculum taught by trained teachers—and that is something we have been hearing over and over today—is imperative. We have done a quantitative study in Massachusetts in that we have an average of about 70 percent of the young people, grades K-12 now receive 16 or more hours of drug and alcohol education. And that big concerted effort really, the Congress and you Senators can take a lot of credit for that, because the Federal Omnibus Drug Bill and the drug-free schools effort created the funding that encouraged the school to do that, to

purchase curricula and train teachers. So we are very happy with that.

We have trained over 9,000 peers. We have 200 high schools now with peer leadership programs, very active. What we are seeing now is over the last 3 years when we compare our high school senior drug use studies, state-wide studies, with the Federal studies, we are seeing a dramatic decline, a decline that is 5 times the national average, in crack and cocaine use by Massachusetts high schools seniors to the national average.

That is encouraging. But we do not want to be over-encouraged by that. Those numbers are young people who have remained in school. Our big effort is to have stronger early intervention programs in our schools so that we are not losing a high percentage of dropouts that you have reading about and that the Nation is so concerned about.

The recent NIDA study that just was released said that, yes, indeed, drug use amongst our Nation's youth is declining. Well, that is a deceiving statistic. The fact is that drug use among the chronic drug users is increasing dramatically. And those are the populations that tend to be poor, underserved, they are in the inner cities primarily. And they are contributing to a great deal of the crime. Because if you drop out of school, there is one avenue open to you. And that is dealing drugs. And that is it.

So we need stronger intervention programs. I think we really need to look hard at what we mean, and have the Congress define what we mean, by drug and alcohol education with trained teachers and obviously appropriate curriculum beginning in kindergarten or preschool.

And I would just like to pitch hard that we need to start early, and the intervention programs are equally as important, and the community as a whole needs to be brought in with parent education and training.

Keema is a beautiful example of a young person who gets drug and alcohol education in her school, is a peer leader in her school, is a peer leader from a community-based program, and also is on loan to her church where she reaches out to the young people in the church. And that sort of encapsulates what I think is a very ideal and good model to begin, just begin, this massive process.

Thanks.

The CHAIRMAN. Very good. I want to again thank Shannon Jones and Keema McAdoo. And I give you a lot of credit for what you are doing. You are setting a very important example. And I know it is not easy. But you really have made a very important difference, in just being here and telling us about your story. Hopefully it will help us to try and support those kinds of efforts in other communities and give similar opportunities to other young people.

So we are very, very grateful to you.

Ms. MCADOO. Thank you. They told me to say this back at home. When I came down here, when they found out I was coming to Washington, they said tell the people in Washington we like saying no. But no sounds like an empty word so bring us back something to say yes to.

The CHAIRMAN. I do not know who they are.

Ms. MCADOO. My peers.

The CHAIRMAN. That is good. Whoever they are, they are wise. That is absolutely the right question.

Thank you very, very much.

Our final panel: Dr. Sidney Shankman is director of the Second Genesis, a residential drug treatment program in the Washington Metropolitan area. Second Genesis currently enrolls about 300 clients at five sites. It is widely regarded as an effective treatment program. I am looking forward to Dr. Shankman's insights into the role of effective treatments in the war on drugs.

And then we have Thomas Freestone, supervisor, District One, Maricopa County, AZ, and a leader of the anti-drug efforts in Maricopa County. We look forward to hearing from you.

Dr. Shankman, we will start off with you.

**STATEMENTS OF DR. SIDNEY SHANKMAN, DIRECTOR, SECOND GENESIS, WASHINGTON, DC, AND THOMAS L. FREESTONE, BOARD OF SUPERVISORS, PHOENIX, AZ**

Dr. SHANKMAN. My name is Sidney Shankman. I am a psychiatrist, both a child and adolescent psychiatrist and an adult psychiatrist, and the founder and executive director of Second Genesis.

As its name implies, Second Genesis is a program that offers a new beginning for individuals with previously irresponsible lifestyles. It is a program that offers an opportunity to turn their lives around. It is a therapeutic community which is a highly structured, nonpermissive, chemically-free, 24-hour a day setting.

We have been in the Washington area for some 20 years. And we have five facilities with now about 350 residents in the District of Columbia, Montgomery County, Prince Georges County, Alexandria, and Annapolis.

There are three cardinal rules of the therapeutic community. There can be no drugs, there can be no violence, and there can be no threat of violence. The concepts are simple but really rather profound. They are based on the concept of self-help, the dignity of labor, and choice.

The only lock we have on our door is to enter. We are firm believers that you cannot make the right choice unless you have the right to make the wrong choice. But you must accept the consequence of either.

Frequently Second Genesis has been called a school of life that educates young people that really never learned to live without hurting themselves or others, without ever feeling worthy. The goal of the program is to learn to lead drug-free, trouble-free lives which allow these individuals to function responsibly and independently and perhaps for the first time in their lives with dignity.

We take both men and women. The youngest person we have in our facility is 14 years old; the oldest is in his fifties. These are basically dually diagnosed individuals, people who have substances use disorders as a primary diagnosis, and also have what we call personality disorders. These are deeply ingrained, maladaptive patterns of behavior of long-standing duration. They are highly manipulative. They are very self-destructive. They are usually not amenable to short-term treatment—most of them have been in

three and four short-term treatment programs—and clearly people for whom traditional methods simply do not work.

At Second Genesis we believe that drugs are a symptom of a problem. Not everyone is a candidate for a therapeutic community. And to this end we do a diagnostic evaluation, including a medical evaluation, psychiatric and psychological, education, eventually vocational assessment, and then for each individual we set up an independent treatment plan incorporating individual, group, and family therapy.

The staff is a multidisciplinary one. Psychiatrists, physicians, psychologists, psychiatric social workers, addiction specialists, education and vocational specialists. Basically we are a total program.

There are three phases of our program. The first phase is that point in time where the individual lives in the program, goes to school, and works there. The second phase in the program is where they live in the program, have their therapy in the program, but go out to school or work. The third phase is where they live out and work out. It is the phase we refer to as detoxification and treatment.

And once the individual has at least a GED, has set up an independent living program, his or her own apartment earned by his or her own money, and has a vocationally sound plan that is operative, then he graduates.

But throughout treatment we reach not only the people in our program. In public health you measure success not by the people you see, but the people that do not have to come to you. And to this end we send these young people out to the schools. And they are incredible role models to show that there is an alternative to drug abuse. In this area, we have reached thousands of young people who have heard what it is to use drugs from the other side.

We go out to schools. We go out to organizations, churches, and other groups.

The basic axiom at Second Genesis is that you never take anything away from someone unless you have something better with which to replace it. We replace drugs not with other drugs but with alternatives to a self-destructive lifestyle.

People can be self-referred. They can be referred by agencies, by the judges, by religious groups. They can be referred by anyone. Most of the people who come to us are indigent. And even those who came from families where there was money, they have so exhausted the patience of those families, of the financial resources, that for all practical purposes they too are indigent. But if a person can pay, they must. And since drugs are equal opportunity destroyers, you better believe they come from every socioeconomic, racial, religious, or whatever group.

The adult program lasts about 1 year. And it is $32 a day. The adolescent program is 8 months and costs $35 a day. We are funded by State, local, and private institutions and private groups.

Treatment works. And we have living examples. You measure success not by what happens when a person is in your program, but what happens when they leave. Examples of successes—and these are not anomalies, Senator Kennedy. These are indicative of many others.

These twins, they would have died in utero, or been born addicted with irreversible brain damage. Their mother came into the program, graduated college. These children have a bright future. But most importantly, they have their mother. They were born chemically-free, and we were able to assist them in obtaining the greatest gift at all, the gift of life itself.

Another example, perhaps an example of hundreds, hundreds of others, is this young woman, Mary. She turned to prostitution and crime to support her drugs, to mask the pain that living with drugs had caused her. Mary is now a program analyst. Her child was born in our program and is doing beautifully.

This young man reminds me of one of Cervantes' characters. He was not going to go through life unnoticed. This young man was facing 20 years in jail for drug-related crimes. When he was referred to us, they found him with a syringe in his arm. That same arm, used to write papers, earned him a BA degree and a Phi Beta Kappa key. He is now a Ph.D. student at the University of Virginia.

Another young man, four blocks from this institution was standing on a roof 4 years ago ready to jump. He now is one of the Nation's top designers, and designed the podium used for the Academy Awards.

It seems to me to understand the importance of saying yes to life, you must understand the consequences of saying no. When these people come to us, for whatever reason, whether it is fear or anguish or despair or emptiness, from whatever source, they are used to instant gratification. And if you put their name on a waiting list, if you withhold help, if you deny help, you at best are committing these people and their families to a life of hell.

In the District of Columbia area, if a person has a $100 a day habit, unless they turn to prostitution or to crime, they must steal $1,000 a day, because a $100 TV set brings you $10. To incarcerate this same individual costs about $58 a day. And then the rate of recidivism is in the high 90 percentile. You only perpetuate the cycle of despair.

In my judgment, Senator Kennedy, to withhold help from these young people, representative of thousands, where we have proven that we can offer an alternative, to deny it is a moral felony. Our waiting list, this last year we turned away 2,264 people. The year before, 1,848. Our current waiting list is 544. And we stop taking names when there is no hope of entry in a reasonable period of time.

What do I tell Mary, a young woman like this, who becomes pregnant and says I want help? How can I tell her there is no room at the inn because there is no inn. We need existing dollars. We need existing zoning. We have to help people to understand that if they do not assist us in this area—everyone loves us, but not in their neighborhood. Once we move in, we get proclamations. We need start-up costs for dollars, we need zoning changes to permit us to come.

Senator Kennedy, if I wanted to destroy a Nation, I would not send planes or tanks, I would send drugs. Neitsche said that if man has a "why" for which to live, he will find a "how."

If it is true that our youth are our Nation's most important commodity, then the term "war" against drug abuse is not a melodramatic term, it is an altogether fitting one. Our youth are the "why" for which we live. The therapeutic community and Second Genesis only provide the "how."

Thank you.

[The prepared statement of Dr. Shankman follows:]

## PREPARED STATEMENT OF SIDNEY SHANKMAN, M.D.

As the name implies, Second Genesis is a program that offers a new beginning for young people with drug and alcohol problems and previously irresponsible lifestyles. It is a program that provides a second chance, an opportunity to turn their lives around. The Second Genesis therapeutic community is a highly structured, non-permissive, 24-hour-per-day, chemically-free, residential treatment program. Founded 20 years ago, Second Genesis now operates five facilities serving over 300 residents in Maryland, Virginia and Washington, D.C.

There are three cardinal rules at Second Genesis. There can be no chemical use, no violence and no threat of violence.

The concepts of Second Genesis are simple but profound. They are based on the concepts of self-help, the dignity of labor and the importance of "choice." It is the belief at Second Genesis that an individual cannot make the right choice unless he or she has the right to make the wrong choice and to accept the consequences of either. For that reason, the only lock at Second Genesis is on the door to enter.

Second Genesis has often been called a "school of life" that educates people who have never learned how to live and feel worthy without hurting themselves or others. The goal of the program is to to teach individuals to lead drug-free, trouble-free lives, allowing them to function responsibly, independently and with dignity.

**Intake Process and Eligibility**

Both males and females are accepted into the program without regard to race, ethnic group or socioeconomic status; the youngest resident is 14 years and the oldest is in his 50s. Most of these individuals are dually diagnosed (i.e., they have a history of drug abuse that generally masks an underlying disorder and also have deeply ingrained, long-standing maladaptive patterns of behavior suggestive of a personality disorder). These individuals are highly manipulative and self-destructive. They are people for whom traditional methods of treatment have failed, and will never work; these people are usually not amenable to short-term treatment.

Because it is a belief at Second Genesis that drugs are a symptom of an underlying problem, it is important to do a diagnostic evaluation; not everyone is an appropriate candidate for this therapeutic modality. The diagnostic evaluation consists of a medical evaluation, a psychiatric and psychological assessment, an educational assessment and, eventually, a vocational assessment. Once those are completed, the individual treatment plan is set into motion. This includes individual, group and family therapy.

The staff of Second Genesis is multidisciplinary, consisting of a physician and psychiatrist, a clinical psychologist, social workers, facility counselors, family therapists, educational specialists and vocational rehabilitation counselors. Together they promote the total "milieu" approach: throughout treatment it is emphasized that the individual is responsible not just to himself or herself but to the society and the community upon which he or she had previously been parasitic.

There are three phases of treatment. The first phase of the program is focused within the facility, where the individual receives his or her therapy (individual, group and family) and works and goes to school within a family-like setting. During the second phase, the individual lives within the facility, has his or her therapy there, but goes out for school or vocational placement. During the third phase of the program, the individual lives and works outside the facility, but returns for routine urinalysis and to attend group therapy (this is generally the phase known as "detoxification from treatment"). Before a resident graduates, he or she must have attained at least a G.E.D., established a program of independent living and have created a sound vocational plan that is now operative.

There's a basic axiom at Second Genesis: you never take something away from someone without replacing it with something more effective. We at Second Genesis replace drugs not with other drugs, but with an alternative to a destructive lifestyle.

Sources of Referral

Since drugs are "equal opportunity destroyers," all socioeconomic, racial, ethnic and other groups are well represented in our treatment population. Clients can be self-referred or referred by their families, the courts, the schools, various agencies or any other source. Some clients may have families that once could have paid for their treatment, but they have so exhausted the financial resources and patience of those families that they are now indigent as well. However, any individual capable of paying must do so.

Duration and Cost of Treatment

The adult program lasts for approximately one year and costs $32 per day; the adolescent program lasts for about eight months and costs $35 per day. We are funded by contracts with the state and local governments in the jurisdictions in which we operate and by individual and corporate contributions.

Case Examples of Success

The best evidence that treatment works is found in our case histories.

We measure success not by what happens in treatment but by what happens when a resident leaves therapy. Examples of success are the children of former addicts who would have died in utero or would have been born addicted and perhaps suffering irreversible brain damage if their parents continued abusing drugs. Such children have been given a chance for a bright future with parents free of drugs. These cases measure success with the most important gift of all, the gift of life itself.

Another example of the success of the program, an example that is typical of many others, is that of a young woman who turned to prostitution and crime to supply her drug habit and to mask the pain that living with drugs had caused. Today that young woman is a program analyst and will graduate at the top of her class.

Another typical example is that of a young man who was facing 20 years for drug-related crime. He, like many of Cervantes' heroes, was not going to go through life unnoticed. He was referred to us by a judge who had heard that the young man was found with a syringe in his arm. That arm is now being used to write papers that earned the fellow a B.A. and a Phi Beta Kappa key. He is currently a Ph.D. student in psychology.

Another young man was standing on a roof getting ready to jump because he felt absolute despair. This young man completed the Second Genesis program and started using design skills he never knew he had; he is now one of the nation's top designers. He recently designed the podium for the Academy Awards ceremony.

These are not anomalies; they are cases indicative of hundreds of other young people who are monuments to the success of the Second Genesis process. Success cannot be measured by the duration of treatment or the terms under which an individual terminates treatment. We measure success not by what happens when that individual is in treatment but rather what happens when that individual reenters society. Approximately 90 percent of those who graduate the program continue to lead the responsible lifestyle they learned at Second Genesis. Those who leave after six months or more in treatment show increases in employment, education levels and social function, improved health and decreases in drug use and criminal activity. (This was the result of an independent study done by the Northern Virginia District Planning Commission).

In addition, young people who have been through treatment offer invaluable public assistance and public service. They provide drug-free education by going into the schools to describe the negative side of drug abuse, engaging in "fire prevention" rather than "firefighting." They are living proof to their audiences that there is an alternative to drugs. Their outreach activities include speaking to religious groups and civic organizations and helping with community activities such as "Toys-for Tots," etc.

Because of the effectiveness of their experience, these young people also work with the staff of Second Genesis to help other states develop similar treatment programs across the nation. Second Genesis has also been featured in CBS and NBC network specials. The Second Genesis treatment program is practical and duplicatible. On an international level, Second Genesis has assisted other countries (the United Kingdom, Israel, Italy and the Netherlands) in establishing similar programs.

The greatest problems that we face as a nation and the greatest needs we have involve addressing the issue of "denial." All too frequently in America we hear "not my child." That is something that I label the "American dilemma," not because it's unique to this country but because it is so prevalent here. We are so determined that our children have everything that we did not have that we often deprive them of something that we did have--discipline. As a psychiatrist (both an adult psychiatrist and a child and adolescent psychiatrist), it is my professional opinion that a frightened child is an undisciplined child. We must break through the "cycle of denial" by helping parents (who see their children as extensions of themselves) to realize that they must take an authoritative position. There were good parents before there were good psychiatrists. Parents must not abdicate their role as parents. It is important to teach parents to say "no."

Another problem that we have is the critical need to provide additional treatment dollars so that we can say "yes" to life. To appreciate the importance of saying yes, we must understand the consequences of saying "no." For whatever reason a young drug abuser comes to us (e.g., fear, anguish, despair or emptiness) or from whatever referral source, the addict has been accustomed to instant gratification. To place one of these young people on a waiting list or to deny them immediate help, will, at best, subject them and their families to lives of hell; at worst it will assign them a death sentence. The cost to society cannot be measured when these young people turn to prostitution, dealing drugs or committing other crimes--as indeed they <u>will</u> and <u>must</u> to support their habits. In Washington, if an individual has a $100-a-day habit, if he or she does not sell drugs or engage in prostitution, he or she must steal $1,000 a day to support that habit (because the return for stolen merchandise is only 10 percent). To incarcerate an individual (at the cost of $54 a day) is to perpetuate the "cycle of despair" as that person will most likely, when released from jail, return to crime. To withhold help from those who need it and are amenable to it is, in my professional judgment, a "moral felony."

A third problem we face is the urgent need to alter existing zoning restrictions. Everybody admires the work of therapeutic communities once they have observed them, but no one wants them in their neighborhood.

Ironically, once we are operational in a jurisdiction, we often receive proclamations of support from local government. (e.g., in Washington, even if I were given a fully equipped building, it would take two years to go through existing zoning procedures before we would be allowed to use that building.) The effects of the constraints are devastating. How do I tell a young pregnant mother, for example, who desperately turns to us for help, that there is no room at the "inn" because there is no inn? To do that is to be, in my professional judgment, a co-conspirator in a crime against society.

If I wanted to destroy a nation, I would not send bombers or tanks, I would send drugs. If it is true that our children are our nation's most important commodity, then the term "war against drugs" is not a melodramatic term but an altogether fitting one. As a philosopher once said, "If man has a 'why' for which to live, he will find a 'how'." Our children are our "why," Second Genesis and the therapeutic community is a very effective "how."

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Alan M. Rodkin, Ph.D.
Deputy Executive Director

20
Two Decades
Rebuilding
Shattered
Lives 1969
1989

**Testimony by Sidney Shankman, M.D.**
**Executive Director of Second Genesis, Inc.**
**Before the Senate Committee on Labor and Human Resources**

**Thursday, August 3, 1989**

**OUTLINE**

1. **Description of Second Genesis Program**
   - A. geographical range of facilities
   - B. concepts of treatment--drug abuse is a symptom of underlying problems
   - C. mission statement of Second Genesis
   - D. intake criteria and client eligibility
   - E. diagnostic procedures
   - F. types of therapy provided
   - G. description of staff--multidisciplinary
   - H. three phases of treatment

2. **The Axiom of the Concept of Treatment**
   - A. replacing drugs with an alternative to a self-destructive lifestyle
   - B. referrals and treatment population

3. **Cost For Care and Sources of Funding**

4. **Measuring Success**
   - A. case examples of success--indicative of hundreds like them--monuments to the success of the Second Genesis program

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Howard A. Hoffman, M.D.
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Michael J. Jackson
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Arthur Andersen & Co.
Walter C. Wright
Dean Witter Reynolds, Inc.

**Testimony Outline**
**Page Two**

4. **Measuring Success, Continued**

   B. ways to measure success
   C. Northern Virginia District Planning Commission Independent Study--long-term residential treatment: research shows that the longer someone is in treatment the greater the chance of success
   D. giving something back to society
   E. sharing successful treatment methods locally, nationally and internationally

5. **The "American Dilemma"--Problems Associated With Denial**

   A. the importance of discipline and teaching our children that drug use is a not a negotiable way of handling stress

6. **Obstacles to Providing Treatment**

   A. the need for treatment dollars--saying "yes" to life
   B. the need for additional bed space vs. the lack of bed space; the effect of ignoring the plea for help and the consequences of saying "no": a "moral felony"--jail as an alternative perpetuates the "cycle of despair"
   C. the need to alter limits imposed by existing zoning restrictions for establishing therapeutic communities

7. **Concluding Remarks: Treatment Is the Answer --Providing the Greatest Gift of All, the Gift of Life Itself**

**Important Questions to be Addressed:**

1. How do you measure the success of your program?

2. What are the greatest problems treatment professionals face in trying to provide treatment?

3. How does Second Genesis establish a waiting list; how many are turned away because bed space is not available?

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## INFORMATION SHEET

SECOND GENESIS, INC., a private, nonprofit, residential program, specializes in providing rehabilitation services for adults and teenagers with drug and alcohol problems. Founded in 1969, Second Genesis operates five residential therapeutic communities serving Maryland, Virginia and Washington, D.C. Treatment consists of a highly structured, thoroughly supervised, 24-hour-per-day, chemical-free residential program.

The Second Genesis program has often been described as a school that educates people who have never learned how to feel worthy without hurting themselves and others. Second Genesis helps people who have tried again and again to get what they want from life and have continually defeated themselves. Treatment combines the basic human values of knowledge, love, honesty, responsibility and work with the dynamic instrument of intense group pressure in order to recognize and help correct the defects that prevent people from living by these values. The result is rehabilitation so that the individual may reenter his or her community as an independent and productive person.

The program is staffed by a multidisciplinary professional team directed by Sidney Shankman, M.D., a psychiatrist, and Alan M. Rochlin, Ph. D., a clinical psychologist. The staff includes master's degree mental health and vocational rehabilitation counselors, learning disabilities specialists, family therapists, a research analyst and facility counselors, many of whom have completed treatment communities like Second Genesis and have gone on for further training as mental health professionals. This diversity of specialized skills permits the selective application of group therapy, individual counseling, family therapy and educational and vocational services.

Second Genesis generally accepts applicants 14 years of age or older, male and female, without regard to race, ethnic group or socioeconomic status, who are all striving for the common goal of self-reliance. Treatment helps people discover love and self-respect in a family-like setting.

Second Genesis is funded primarily through contractual arrangements with state and local governments for individuals unable to pay for their treatment costs. Each funding source has its unique eligibility criteria. Supplementary funding is received in the form of cash and in-kind contributions from individuals, organizations, religious groups and businesses.

The cost effectiveness of Second Genesis might best be judged by the following current per diem comparisons:

Psychiatric hospitalization.....$600

Incarceration (average).....$54

Second Genesis

adult program.....$32
adolescent program.....$35

It is estimated that Second Genesis will need to raise $1,026,155 from community contributions to compensate for underpayment of client treatment costs and to provide for payments of clients in treatment who are not funded by contract sources. Contributions may be sent or additional information may be obtained by contacting Mrs. Ruth N. Cavanagh, Director of Community Relations and Development.

Second Genesis means a new beginning, a second chance, often the last chance for many who are referred by the courts, agencies, professionals or schools or those who contact Second Genesis directly.

**Anyone can make referrals by contacting**

The Admissions Department

7910 Woodmont Avenue
Suite 500
Bethesda, Maryland 20814-3048
Telephone: 301-656-1545

Licensing certification and approval for Second Genesis are provided by the Department of Social Services, Juvenile Services Administration and Alcohol and Drug Abuse Administration of Maryland; the Virginia Department of Mental Health and Mental Retardation; and the District of Columbia Department of Human Services.

The CHAIRMAN. Thank you very much. Just one or two brief questions, and then I will hear Mr. Freestone.

Do you have a review of what has happened to your graduates, about where they are? I know you always get asked this, and I want to ask you about, you know, what they call success. We have different definitions about what success is.

Dr. SHANKMAN. We have over 1,000 graduates of Second Genesis. And of those who have graduated, less than 15 percent returned to the previous lifestyle.

But I must tell you, Senator Kennedy, it is very ill-advised to measure success by the duration of treatment or even the terms under which a person leaves treatment, whether they abscond. An independent study was done by the Northern Virginia Planning Commission, and they proved for even people who abscond or who leave, if they have stayed in the program 6 months or longer, there is a marked increase in employment and education, an increase in social functioning, an increase in health, a decrease in usage, and a decrease in criminal activity.

So you have got to be careful about it when you assess numbers even for those who graduate or those who do not. But 20 years of evidence would show that treatment works.

The CHAIRMAN. I am going to submit some additional questions to you. We will hear from Mr. Freestone.

Mr. FREESTONE. Thank you very much.

The CHAIRMAN. Perhaps if you would be good enough to capsulize your statement. I apologize.

Mr. FREESTONE. Yes, that is quite all right. I appreciate it very much.

Indeed it is a pleasure to be here. I left an Arizona that was cooling down to 110 yesterday, so it is good to be here.

Let me tell you briefly—and I going to abstract——

The CHAIRMAN. We will include your entire statement in the record.

Mr. FREESTONE. Okay, I appreciate it.

First of all, I would like to state we have a very serious problem in this country, particularly where I come from, because we have a large notch group that is not being looked to, and that is unaffordable rehabilitation.

I have had a personal experience with this because I had a son that got entangled into drugs. And it gave me a whole new perspective on the problems that we face as a society. And I can tell you that even though it takes, like you have seen testimony here this morning, for those who have finally have hit the bottom, there are as many as those that never will come back when the hit bottom. Also it is unnecessary for them to hit the bottom to first recognize that they need to make a comeback.

I feel that within the families that were poorly educated to deal with the problem of our youth, particularly our children, once they become entangled in drugs for various reasons, whether it is peer pressure, whether it is rejection in society because of a move across town or out of State and they have a hard time readjusting, that we do not handle these problems properly. I know we did not as parents. And thank God that we had insurance and we had the fi-

nancial means, that when our son was ready and willing over a period of years to make a comeback, we had the resources to do it.

I think it is important that we develop affordable rehabilitation and also an educational process. Because without it, we will have millions that will languish in this problem and we will continue to have a devastating effect upon our Nation. It is a very serious problem that we need attend to.

I have always believed in stern law enforcement. But obviously that is not correcting the problem.

We have too many users out there that are addicted. That is creating a tremendous need for the drugs. And we have too many criminals that are willing to run the risk because of the high profits. Therefore, we need to work on the demand side if we wish to, want to, limit the supply side.

And so I strongly urge this committee as they look into this, that they would look at this large notch group that we have left out there with no place to go, no ability to pay for it. Unfortunately, institutions like yourself, Dr. Shankman, are not available.

We find them far and few between in our county, our State. We have a growth problem. We have a bulging jailing problem. We have a financial crisis problem. And I think it is time that we get down and see that the economic tradeoff is if we can keep them out of the criminal justice system, it makes the rehabilitation system look pretty inexpensive. And also the moral part of it, we should be doing this regardless of the cost.

We were willing, if we had to, to sell all we had, even if it meant bankruptcy, if that is what it took, to save our son. And I think we ought to look about this Nation. We need to do what we have to do if we wish to save the children of America, our future adults.

Thank you very much.

[The prepared statement of Mr. Freestone (with additional copy) follows:]

## PREPARED STATEMENT OF THOMAS L. FREESTONE

THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, FOR THE OPPORTUNITY TO TESTIFY BEFORE YOU.

MY NAME IS THOMAS FREESTONE. I AM THE DISTRICT 1 SUPERVISOR FROM MARICOPA COUNTY, ARIZONA. I AM HERE TODAY, SPEAKING NOT ONLY AS AN ELECTED OFFICIAL BUT AS A PARENT OF A YOUNG MAN WHO HAS HAD PROBLEMS WITH DRUGS.

I MUST CONFESS UP FRONT THAT I HAVE NO OBJECTIVITY ON THE SUBJECT OF DRUG ABUSE. IT HAS HIT TOO CLOSE TO HOME FOR ME TO BE OBJECTIVE. I THINK DRUG ABUSE IS THE MOST SERIOUS PROBLEM FACING AMERICA. I KNOW, FIRSTHAND, HOW IT ATTACKS SOCIETY AND, MORE IMPORTANTLY, THE FAMILY.

DURING THE LAST 10 YEARS OF MY MORE THAN 20 YEARS OF PUBLIC SERVICE, I HAVE BEEN FIGHTING THE PROBLEM OF DRUG ABUSE. WHEN I BECAME A SUPERVISOR IN 1978, I WAS DETERMINED TO ATTACK THE DRUG PROBLEM WITH A TWO-PRONGED APPROACH. I FELT THAT STRONG LAW ENFORCEMENT AND OUTSTANDING COMMUNITY-BASED TREATMENT PROGRAMS WERE THE BEST ANSWER TO SOLVING THE PROBLEM. TODAY, I STILL BELIEVE IN THAT APPROACH.

TO GET STRONG LAW ENFORCEMENT AND GOOD TREATMENT PROGRAMS, IT WAS NECESSARY TO HAVE ACTIVITY COORDINATION AND RESOURCE MOBILIZATION. FOR THIS REASON, I STARTED MY DRUG FIGHT BY SERVING ON THE REGIONAL COUNCIL OF GOVERNMENT'S CRIMINAL JUSTICE COORDINATING COMMITTEE. IT WAS THIS GROUP'S RESPONSIBILITY TO PLAN, DEVELOP AND

MONITOR PROGRAMS FUNDED WITH FEDERAL DOLLARS PROVIDED BY THE LAW ENFORCEMENT ASSISTANCE ADMINISTRATION, OR LEAA. AS YOU MAY REMEMBER, LEAA FUNDED START-UP PROGRAMS FOR THREE YEARS. WITH THE MONEY, COMMUNITIES IN MARICOPA COUNTY WERE ABLE TO DEVELOP A NUMBER OF PROGRAMS DIRECTED AT DRUGS AND YOUTH, INCLUDING A POLICE-SCHOOL PROGRAM, POLICE YOUTH RECREATION PROGRAM, POLICE YOUTH GANG PROGRAM, PROSECUTION-DIVERSION PROGRAMS, PLUS THE PURCHASE OF EQUIPMENT TO HELP MAKE LAW ENFORCEMENT MORE EFFICIENT.

TODAY, MOST OF THESE PROGRAMS ARE IN PLACE. THE STATE HAS ADDED FUNDS, ESPECIALLY IN LAW-ENFORCEMENT TRAINING.

ALSO, DURING THE LATE 1970S, I WAS ABLE TO HELP A NUMBER OF COMMUNITY-BASED TREATMENT PROGRAMS GET STARTED. THESE TREATMENT PROGRAMS WERE DESIGNED TO HELP INDIVIDUALS RECOVER FROM DRUG DEPENDENCY.

MARICOPA COUNTY, UNLIKE MOST OTHER GOVERNMENTS, NEVER USED ITS FEDERAL REVENUE-SHARING DOLLARS TO HIRE COUNTY EMPLOYEES. INSTEAD, I WAS ABLE TO CHANNEL MUCH OF THE COUNTY'S REVENUE-SHARING DOLLARS TO COMMUNITY-BASED TREATMENT ORGANIZATIONS. THESE COMMUNITY PROGRAMS WOULD PROVIDE VOLUNTEER COMMUNITY LEADERSHIP AND PRIVATE DOLLARS FROM BUSINESS AND INDUSTRY TO MATCH THE COUNTY REVENUE-SHARING MONEY. TOGETHER, THE COMMUNITY WAS ABLE TO DEVELOP RESOURCES TO PROVIDE FOR THE TREATMENT.

IT WAS IN THIS PERIOD OF TIME THAT I DISCOVERED THE UNITED WAY AND CAME TO BE A CHAMPION OF THEIR APPROACH. STILL TODAY, I AM A VOLUNTEER FOR THE MESA, ARIZONA, UNITED WAY.

ON THE SELFISH SIDE, I AM GLAD THAT MARICOPA COUNTY INVESTED ITS REVENUE-SHARING FUNDS IN TREATMENT PROGRAMS. WHEN MY CHILD DEVELOPED HIS DRUG PROBLEM, THERE WAS A PLACE FOR HIM TO GO FOR HELP. I AM HAPPY TO REPORT THAT TODAY, HE IS DRUG FREE. I AM ALSO HAPPY TO REPORT THAT THERE ARE STILL TREATMENT PROGRAMS AVAILABLE IN MARICOPA COUNTY TO HELP THOSE WITH SUBSTANCE ABUSE PROBLEMS.

I AM UNHAPPY TO REPORT THAT IT IS MUCH MORE DIFFICULT FOR THESE COMMUNITY BASED ORGANIZATIONS TO FINANCE THEIR ACTIVITY THAN IT WAS 10 YEARS AGO. MOST OF THE FEDERAL MONEY IS GONE. THE CITY, STATE AND COUNTY GOVERNMENTS HAVE BEEN ABLE ONLY TO MAINTAIN THEIR PARTICIPATION -- NOT SUPPLANT THE FEDERAL DOLLARS LOST WITH NATIONAL BUDGET REDUCTIONS.

AS OUR POPULATION INCREASES, TREATMENT PROGRAMS WILL HAVE LESS CAPACITY. TOO SOON, THERE WILL BE NO TREATMENT LEFT.

TEN YEARS AGO, MARICOPA COUNTY, ITSELF, ALSO LACKED COORDINATION WITHIN ITS OWN AGENCIES. UNLIKE MOST OF AMERICA'S COUNTIES, MARICOPA COUNTY IS LARGE. BOTH IN TERMS OF LAND MASS AND POPULATION, MARICOPA COUNTY IS BIG -- IN FACT, BIGGER THAN SOME STATES.

WITH OVER 9,000 SQUARE MILES AND 2 MILLION PEOPLE, MARICOPA COUNTY IS WELL WITHIN THE TOP 20 COUNTIES IN THE NATION, BY ANY STANDARD OF MEASURE. THE COUNTY HAS MORE THAN 12,000 EMPLOYEES. SO YOU CAN SEE HOW IMPORTANT COORDINATION HAS TO BE. TEN YEARS AGO, THERE WAS NEXT TO NOTHING.

ONE OF MY FIRST TASKS AS SUPERVISOR WAS TO DEVELOP THE MARICOPA COUNTY CRIMINAL JUSTICE COORDINATING COMMITTEE. THE COMMITTEE BROUGHT TOGETHER THE TOP ELECTED OFFICIAL AND DEPARTMENT HEADS TO EXCHANGE INFORMATION AND DEVELOP PLANS FOR DEALING WITH THE CRIMINAL JUSTICE SYSTEM -- THE SHERIFF, PRESIDING JUDGE OF THE SUPERIOR COURT, COUNTY ATTORNEY, PUBLIC DEFENDER, CLERK OF THE SUPERIOR COURT AND BOARD OF SUPERVISORS, ALL WORKING ON A COMMON PROBLEM.

TO BEGIN, THE MAJOR PROBLEM WAS JAIL SPACE. WORKING TOGETHER, WE ATTACKED THE PROBLEM AND CONVINCED THE COMMUNITY, WHICH PASSED A MAJOR BOND ISSUE. COORDINATION WAS UNDER WAY.

AS PLANS WERE BEING DEVELOPED FOR THE JAIL, A NEW TREND WAS DEVELOPING IN THE DRUG DELIVERY SYSTEM. STARTING FIRST WITH MARIJUANA AND THEN WITH OTHER DRUGS, MEXICO BECAME A MAJOR DRUG EXPORTER.

MARICOPA COUNTY, WITH PHOENIX AS ITS COUNTY SEAT, WAS LESS THAN 200 AIR MILES FROM MEXICO. SUDDENLY THE HUNDREDS OF AGRICULTURAL AND MILITARY-BUILT AIRSTRIPS BECAME MAJOR ENTRY POINTS FOR DRUGS.

COUNTY LAW ENFORCEMENT -- PARTICULARLY THE COUNTY SHERIFF -- FELT THAT AN INTERDICTION CAPABILITY WAS NEEDED TO SLOW THE DRUG TRAFFIC.

FOR FIVE YEARS, IN AN ATMOSPHERE OF SHRINKING FINANCIAL RESOURCES, I FOUGHT FOR THE SHERIFF TO GET A HELICOPTER. TODAY, THE SHERIFF HAS THE PROGRAM AND THE NECESSARY EQUIPMENT TO MAKE IT VERY DIFFICULT FOR SMUGGLERS TO USE OUR AIRSTRIPS.

WITH ALL THIS EFFORT, THE PROBLEM CONTINUES, AND IN MANY WAYS GROWS EVEN GREATER. HOWEVER, WE ARE NOT STANDING STILL. MARICOPA COUNTY, WITH THE HELP OF OTHER AGENCIES, HAS TAKEN ADDITIONAL STEPS TO FOCUS ON YET ANOTHER APPROACH. THE COUNTY HAS TWO RELATIVELY NEW PROGRAMS AIMED AT THE DRUG USER, AS OPPOSED TO THE DRUG SUPPLIER.

ONE PROGRAM IS MODELED AFTER A HIGHLY SUCCESSFUL EFFORT THAT WAS DEVELOPED BY THE DISTRICT OF COLUMBIA'S COURT SYSTEM, HERE IN THE CAPITAL.

WORKING THROUGH THE ARIZONA SUPREME COURT ON A PROGRAM SPONSORED BY THE NATIONAL INSTITUTE OF JUSTICE, THE MARICOPA COUNTY SUPERIOR COURT PRE-TRIAL SERVICES HAS DEVELOPED A SYSTEMATIC DRUG-TESTING PROGRAM FOR EVERY FELONY BOOKING IN OUR JAIL. THE PROGRAM IS COMPLETELY VOLUNTARY BUT HAS BEEN SO WIDELY ACCEPTED THAT NEARLY EVERYONE AGREES TO TAKE THE TEST. INDIVIDUALS RELEASED FROM JAIL IN THE PRE-TRIAL PERIOD CONSENT TO REMAIN DRUG

FREE. THEY ALSO AGREE TO FOLLOW-UP DRUG TESTS TO GUARANTEE THEIR DRUG-FREE STATUS. CURRENTLY, THE PROGRAM IS BEING FUNDED BY FEDERAL DOLLARS. I FEEL THAT, IF THE PROGRAM CONTINUES TO BE AS SUCCESSFUL AS EARLY RESULTS INDICATE, LOCAL TAX DOLLARS WILL SOON BE SUPPORTING THE PROGRAM. HERE IS YET ANOTHER EXAMPLE OF THE FEDERAL GOVERNMENT AND THE COUNTY GOVERNMENT WORKING TOGETHER. PARTNERSHIPS LIKE THIS, I FEEL, ARE NECESSARY TO MAKE ANY DRUG PROGRAM SUCCESSFUL.

THE OTHER PROGRAM IS A DEMAND-REDUCTION PROGRAM. FOR YEARS, LAW ENFORCEMENT AGENCIES HAVE SPENT MILLIONS ATTACKING THE SUPPLY SIDE OF DRUGS. MARICOPA COUNTY IS FOCUSING ON THE DEMAND SIDE OF DRUGS BECAUSE, WITHOUT A DEMAND, THERE IS NO SUPPLY. IN MARICOPA COUNTY, 26 LAW-ENFORCEMENT AGENCIES -- LOCAL, COUNTY, STATE AND FEDERAL -- ARE PARTICIPATING IN AN EFFORT TO OFFER FIRST-TIME OFFENDERS A CHANCE TO START OVER, AND THE COMMUNITY A CHANCE TO CHANGE THEIR ATTITUDE ABOUT DRUG USE.

THE DEMAND-REDUCTION PROGRAM, ONE OF THE FIRST OF ITS KIND IN THE COUNTRY, HAS TWO COMPONENTS. ONE IS A HARD-HITTING NEW ANTI-DRUG CAMPAIGN. LAUNCHED MARCH 7, CALLED "DO DRUGS, DO TIME." THE CAMPAIGN USES ALL FORMS OF MEDIA TO TELL RESIDENTS THAT IT IS NOT ACCEPTABLE TO OCCASIONALLY USE MARIJUANA, COCAINE OR OTHER DRUGS. THE CITIZENS ARE LEARNING THAT A POLICE TASK FORCE IS TARGETING THE CASUAL USER.

CASUAL USE HAS PROVEN TO CONTRIBUTE SIGNIFICANTLY TO THE DEMAND FOR DRUGS. WHEN THE CASUAL USERS ARE ARRESTED, THEY ARE BOOKED ON FELONY CHARGES AND MUST SPEND SOME TIME IN JAIL. THOSE WHO HAVE NO PRIOR FELONY CONVICTIONS HAVE THE OPPORTUNITY TO ENTER A DEFERRED PROSECUTION PROGRAM FOR TREATMENT AND COUNSELING. THE PARTICIPANT IN THE DEFERRED PROSECUTION PROGRAM PAYS ALL COSTS, INCLUDING THAT OF JAILING. IT IS ESTIMATED THAT THIS COST COULD BE UP TO $2,000, DEPENDING UPON THE AMOUNT OF COUNSELING NEEDED. UPON SUCCESSFUL COMPLETION OF THE PROGRAM, THE FELONY CHARGES ARE DROPPED.

I KNOW FROM PERSONAL EXPERIENCE THAT COUNSELING PROGRAMS WORK WHEN THE INDIVIDUAL IS PROPERLY MOTIVATED. COUNSELING IS HOW MY SON ESCAPED ADDICTION. BUT HE WOULD HAVE BEEN BETTER OFF IF HE HAD NEVER STARTED USING DRUGS AT ALL.

NOT STARTING IS WHAT THE SECOND PART OF THE DEMAND-REDUCTION PROGRAM FOCUSES UPON. EDUCATION PLAYS THE MAJOR ROLE IN THIS PART, WORKING THROUGH THE SCHOOLS WITH PROGRAMS LIKE "D.A.R.E." -- DRUG ABUSE RESISTANCE EDUCATION . THIS CAMPAIGN FOR A DRUG-FREE WORKPLACE SHOULD HELP ENCOURAGE PEOPLE NEVER TO START DRUGS. THE ARIZONA GOVERNOR'S DRUG TASK FORCE COMMUNITY AWARE-NESS PROGRAM ALSO HELPS SPREAD THE MESSAGE NOT TO USE DRUGS.

THE PEOPLE OF MARICOPA COUNTY AND I ARE OLD WARRIORS IN THE DRUG PROBLEM. I KNOW THAT MARICOPA COUNTY CANNOT FIGHT THE DRUG PROBLEM ALONE, EVEN WITH THE HELP OF THE FEDERAL GOVERNMENT.

PERHAPS IT IS LIKE HUMPTY DUMPTY -- ALL THE KING'S HORSES AND ALL THE KING'S MEN COULD NOT MAKE THE SITUATION RIGHT AGAIN.

I, FOR ONE, AM WILLING TO KEEP UP THE FIGHT AGAINST DRUGS AND TO PUSH HARDER. I KNOW, TOO, THAT DRUGS ARE EVERYONE'S PROBLEM. DRUGS ARE A NATIONAL PROBLEM; A STATE PROBLEM; A COUNTY PROBLEM; A CITY PROBLEM; A CHURCH PROBLEM; A SCHOOL PROBLEM; A FAMILY PROBLEM; A QUALITY OF LIFE PROBLEM. I KNOW THERE IS NO ONE SOLUTION. WE MUST KEEP ALL OUR PROGRAMS GOING. EVERYONE NEEDS TO DO HIS SHARE.

THE BULK OF ARIZONA'S GROWTH HAS COME IN THE LAST 40 YEARS. THERE HAS ALWAYS BEEN MONEY FOR PLANNING IN ARIZONA, BUT LITTLE FOR IMPLEMENTATION.

MY OFFICE IS FULL OF STUDIES. I KNOW THE NEEDS. BUT THERE IS NEVER ENOUGH MONEY FOR ANSWERS. YOU, ON THIS COMMITTEE, UNDERSTAND THE PROBLEM OF LIMITED RESOURCES. I KNOW THAT AS I WOULD, YOU WOULD LIKE TO HELP EVERYONE AND EVERY CAUSE. LIKE YOU, I KNOW THAT IT IS IMPOSSIBLE. LIKEWISE, I KNOW THAT EVERYONE COMING BEFORE YOU SAYS THE ANSWER TO HIS PROBLEM IS MORE OF YOUR MONEY. IT IS NO SECRET THAT WE NEED YOUR MONEY; WE NEED YOUR SUPPORT. BUT I HAVE FOUND THAT, MORE THAN ANYTHING ELSE, WE NEED YOU.

DRUG ABUSE, I THINK, WILL END WITH A CHANGE IN AMERICAN ATTITUDE. TOGETHER, WE SHAPE THE ATTITUDES OF THE WORLD. AS MUCH AS YOUR MONEY, I NEED YOUR HELP. I DO NOT MEAN LIP SERVICE. I MEAN TRUE HELP.

I AM ASKING EACH OF YOU, AND ALL MEMBERS OF CONGRESS, TO TAKE AN ACTIVE PART IN THE FIGHT AGAINST DRUGS. GIVE US SOME OF YOUR TIME. I KNOW HOW OVERWORKED YOU ARE. I, TOO, REPRESENT A LARGE CONSTITUENCY WITH ALL THEIR DEMANDS. I, TOO, MUST RUN FOR ELECTION. I UNDERSTAND BETTER THAN MOST YOUR PROBLEMS. YES, I WANT YOUR MONEY, BUT -- TO ME MORE IMPORTANTLY -- I WANT YOUR TIME. IF YOU COULD GIVE 100 HOURS OF YOUR TIME EACH YEAR OUTSIDE YOUR OFFICIAL DUTIES -- IF YOU COULD REACH INTO YOUR OWN POCKET FOR A FEW OF YOUR PERSONAL DOLLARS -- THAT WOULD MAKE MY JOB EASIER.

IN CONCLUSION, FOR 10 YEARS I HAVE BATTLED THE PROBLEM OF DRUG ABUSE. MONEY HELPS, BUT IT IS NOT THE ENTIRE ANSWER. YOU CAN HELP PERSONALLY WITH YOUR TIME, MONEY AND ATTITUDE. DRUG ABUSE IS TOO IMPORTANT TO LEAVE TO THE NEXT GUY, OR EXPECT SOMEONE ELSE TO SOLVE. IT'S EVERYONE'S PROBLEM AND EVERYONE'S OPPORTUNITY TO SOLVE.

THANK YOU.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

# ROUTE SLIP

| TO | Take necessary action |
|---|---|
| | Approval or signature |
| | Comment |
| | Prepare reply |
| | Discuss with me |
| | For your information |
| | See remarks below |
| FROM David Rivait | DATE 5/2/89 |

REMARKS

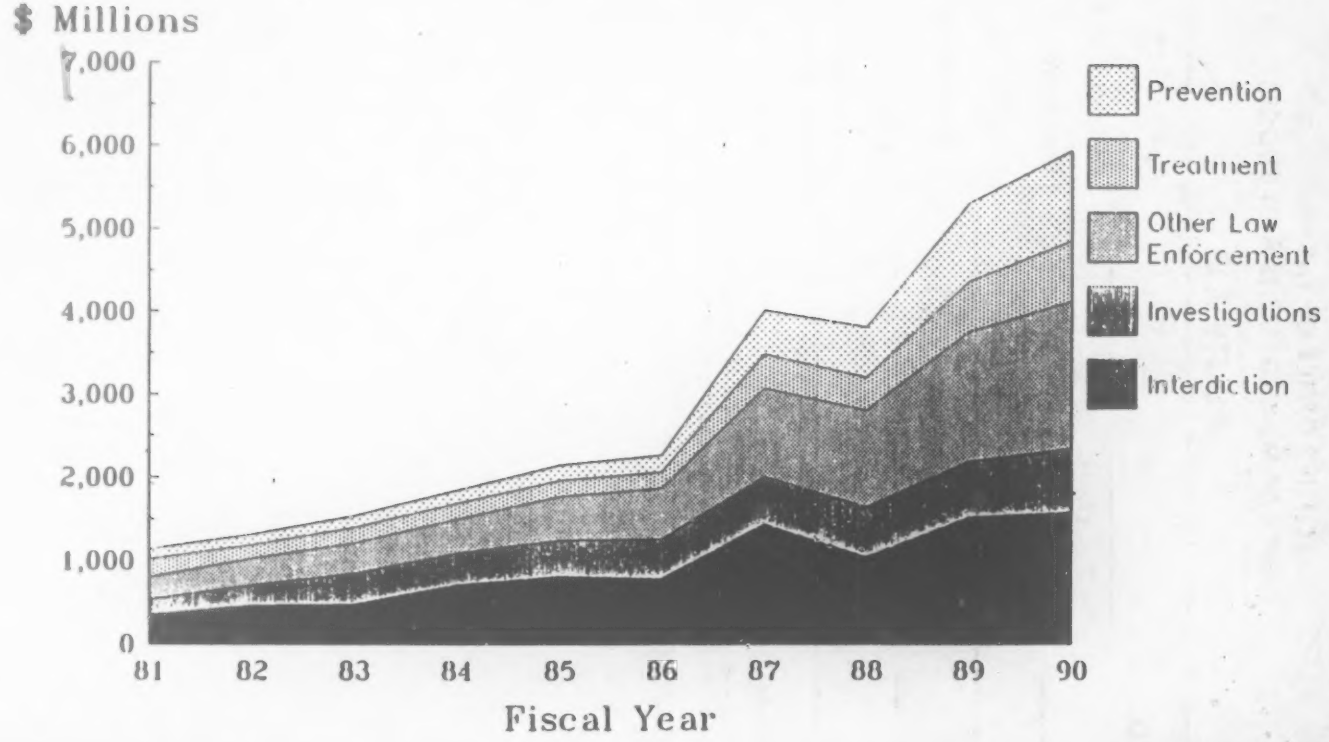
Attached is the material that you requested on drug-related federal spending. I have also included a graph that I prepared which summarizes this information by major functional category

Attachments

OMB FORM
Rev Aug 78

# FEDERAL ANTI-DRUG PROGRAMS

## Budget Authority



# SPENDING BY AGENCY

A1
File name: ROLLUP
By Agency

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Office of National Drug Control Policy | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of Justice | | | | | | | | | | | | |
| DEA | 216.1 | 216.8 | 239.1 | 224.6 | 254.9 | 259.9 | 291.9 | 281.8 | 344.0 | 331.8 | 372.3 | 347.7 |
| FBI | 8.3 | 8.3 | 40.2 | 40.2 | 136.9 | 136.9 | 99.3 | 99.3 | 103.9 | 103.9 | 102.5 | 98.6 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Criminal Div. | 1.6 | 1.5 | 1.9 | 1.8 | 1.8 | 1.7 | 1.9 | 1.8 | 2.7 | 2.5 | 2.7 | 2.6 |
| Tax Div. | 0.0 | 0.0 | 0.0 | 0.0 | 0.8 | 0.8 | 0.8 | 0.8 | 1.6 | 1.6 | 2.0 | 2.0 |
| U.S. Attorneys | 19.5 | 19.5 | 20.9 | 20.4 | 32.7 | 32.0 | 47.7 | 40.7 | 54.8 | 53.7 | 57.3 | 53.3 |
| U.S. Marshals | 26.3 | 25.0 | 29.4 | 27.9 | 31.1 | 29.5 | 36.0 | 34.2 | 48.1 | 45.7 | 52.2 | 49.5 |
| Prisons | 79.7 | 83.1 | 99.4 | 87.8 | 116.5 | 102.4 | 120.9 | 119.3 | 178.8 | 162.6 | 221.7 | 227.8 |
| Support | 5.9 | 5.4 | 8.0 | 7.3 | 13.1 | 12.0 | 16.4 | 15.0 | 19.5 | 17.9 | 21.1 | 19.3 |
| PCOC | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 1.6 | 1.5 | 2.2 | 2.0 | 1.0 | 1.3 |
| INS | 0.3 | 0.2 | 0.3 | 0.3 | 0.4 | 0.4 | 0.5 | 0.5 | 0.5 | 0.5 | 6.5 | 6.5 |
| OJP | 4.5 | 14.7 | 4.4 | 8.0 | 8.8 | 7.1 | 7.4 | 8.4 | 12.9 | 8.1 | 19.9 | 13.3 |
| Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 43.0 | 37.0 |
| INTERPOL | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 |
| Inspector General | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 362.2 | 374.5 | 443.5 | 418.3 | 595.3 | 583.0 | 624.7 | 603.4 | 769.2 | 730.5 | 902.3 | 859.0 |
| Department of Treasury | | | | | | | | | | | | |
| Customs | 136.8 | 137.0 | 141.5 | 138.5 | 137.9 | 133.3 | 227.3 | 177.9 | 302.0 | 260.8 | 311.6 | 278.8 |
| IRS | 35.2 | 35.2 | 44.2 | 44.2 | 50.3 | 50.3 | 57.4 | 57.4 | 61.6 | 61.6 | 63.5 | 63.5 |
| BATF | 0.0 | 0.0 | 1.5 | 0.5 | 4.6 | 2.9 | 8.3 | 8.1 | 9.5 | 9.3 | 7.5 | 7.3 |
| Payments to Puerto Rico | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 172.0 | 172.2 | 187.2 | 183.2 | 192.8 | 186.5 | 293.0 | 243.4 | 373.1 | 331.7 | 382.6 | 349.6 |
| Department of Transportation | | | | | | | | | | | | |
| Coast Guard | 227.8 | 227.7 | 329.2 | 329.2 | 360.1 | 360.1 | 508.6 | 508.6 | 508.2 | 508.2 | 481.4 | 444.3 |
| FAA | 0.4 | 0.4 | 0.2 | 0.2 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.6 | 0.6 |
| NHTSA | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 228.2 | 228.1 | 329.5 | 329.5 | 360.5 | 360.5 | 509.1 | 509.1 | 508.6 | 508.6 | 482.0 | 444.9 |
| Department of State | | | | | | | | | | | | |
| INM | 34.7 | 28.4 | 36.7 | 42.3 | 36.7 | 36.6 | 41.2 | 33.3 | 50.2 | 51.6 | 55.1 | 50.3 |
| AID (Direct) | 0.0 | 0.0 | 15.7 | 1.0 | 9.2 | 5.8 | 10.6 | 7.4 | 7.9 | 4.3 | 25.4 | 16.6 |
| USIA | 1.0 | 0.5 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| SBI | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 35.7 | 28.8 | 53.4 | 44.3 | 46.9 | 43.4 | 52.8 | 41.7 | 59.1 | 56.9 | 81.5 | 75.9 |

A1 09-Feb-89
File name: ROLLUP
By Agency

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of Agriculture | | | | | | | | | | | | |
| Agriculture Research Service | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.3 | 1.3 |
| U.S. Forest Service | 0.5 | 0.5 | 0.7 | 0.7 | 0.8 | 0.8 | 2.6 | 2.6 | 3.0 | 3.0 | 3.1 | 3.1 |
| | 1.9 | 1.9 | 2.1 | 2.1 | 2.2 | 2.2 | 4.0 | 4.0 | 4.4 | 4.4 | 4.4 | 4.4 |
| Department of Interior | | | | | | | | | | | | |
| Bureau of Land Management | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 1.0 | 1.0 |
| U. S. Park Service | 0.1 | 0.1 | 0.2 | 0.2 | 0.5 | 0.5 | 0.7 | 0.7 | 0.8 | 0.8 | 0.2 | 0.2 |
| Bureau of Indian Affairs | 1.7 | 1.7 | 1.9 | 1.9 | 1.9 | 1.9 | 2.0 | 2.0 | 3.1 | 2.9 | 4.5 | 4.5 |
| Fish and Wildlife Service | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.4 | 0.4 | 0.3 | 0.3 |
| | 1.9 | 1.9 | 2.2 | 2.2 | 2.8 | 2.8 | 3.1 | 3.1 | 4.5 | 3.4 | 6.0 | 6.0 |
| Department of Defense | | | | | | | | | | | | |
| Interdiction | 0.0 | 0.0 | 4.9 | 4.0 | 9.7 | 8.0 | 14.6 | 13.0 | 54.8 | 44.0 | 105.7 | 73.7 |
| Demand reduction | 33.6 | 26.6 | 57.6 | 49.2 | 69.7 | 63.9 | 73.9 | 70.2 | 81.5 | 77.0 | 83.0 | 79.8 |
| | 33.6 | 26.6 | 62.5 | 53.2 | 79.4 | 71.9 | 88.5 | 83.2 | 136.3 | 121.0 | 188.7 | 153.5 |
| Department of HHS | | | | | | | | | | | | |
| ADAMHA | 239.0 | 233.3 | 161.1 | 164.2 | 183.1 | 181.7 | 193.4 | 193.8 | 210.6 | 210.7 | 219.4 | 217.4 |
| IHS | 1.5 | 1.5 | 1.6 | 1.7 | 2.1 | 2.0 | 2.3 | 2.2 | 2.4 | 2.4 | 2.4 | 2.4 |
| FDA | 1.4 | 1.4 | 0.8 | 0.8 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 1.6 | 1.6 |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 241.9 | 236.2 | 163.5 | 166.7 | 185.9 | 184.4 | 196.4 | 195.9 | 213.7 | 213.8 | 223.4 | 221.4 |
| Department of Education | 2.9 | 2.9 | 2.9 | 3.5 | 2.9 | 2.1 | 2.9 | 2.7 | 3.0 | 3.7 | 2.9 | 2.3 |
| Department of Labor | 3.4 | 3.4 | 1.4 | 1.4 | 0.6 | 0.6 | 0.4 | 0.2 | 0.4 | 0.3 | 0.1 | 0.3 |
| ACTION | 2.5 | 2.5 | 6.8 | 6.8 | 6.9 | 6.9 | 6.8 | 6.8 | 6.9 | 6.9 | 6.9 | 6.9 |
| White House Conference | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Veterans Administration | 52.0 | 51.8 | 55.8 | 55.6 | 60.5 | 60.3 | 63.3 | 61.1 | 66.6 | 64.3 | 68.4 | 68.1 |
| TOTAL FEDERAL DRUG PROGRAM | 1,138.0 | 1,128.8 | 1,310.6 | 1,266.7 | 1,536.6 | 1,504.6 | 1,844.8 | 1,754.5 | 2,145.9 | 2,045.5 | 2,269.1 | 2,192.3 |

09-Feb-89

# FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

All
File name: ROLLUP
By Agency

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Office of National Drug Control Policy | 0.0 | 0.0 | 0.0 | 0.0 | 3.5 | 2.6 | 3.5 | 2.6 | 12.0 | 9.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 136.0 | 0.0 |
| Department of Justice | | | | | | | | | | |
| DEA | 486.1 | 411.7 | 492.5 | 485.0 | 30.0 | 22.5 | 534.5 | 487.2 | 551.2 | 526.0 |
| FBI | 97.1 | 91.2 | 124.9 | 121.3 | 15.0 | 12.0 | 129.3 | 131.3 | 91.4 | 87.4 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 214.9 | 161.2 |
| Criminal Div. | 3.3 | 3.0 | 9.4 | 9.4 | 1.0 | 0.9 | 10.7 | 10.6 | 10.1 | 10.2 |
| Tax Div. | 2.0 | 2.0 | 2.2 | 2.1 | 0.0 | 0.0 | 2.2 | 2.1 | 0.8 | 0.7 |
| U.S. Attorneys | 74.2 | 69.8 | 80.7 | 79.8 | 55.9 | 49.2 | 141.4 | 139.9 | 113.2 | 112.2 |
| U.S. Marshals | 65.8 | 62.6 | 91.6 | 86.8 | 8.0 | 6.4 | 123.9 | 120.6 | 151.0 | 148.4 |
| Prisons | 304.2 | 262.9 | 414.5 | 410.4 | 43.0 | 4.3 | 579.5 | 498.8 | 664.0 | 614.4 |
| Support | 27.9 | 24.0 | 53.3 | 47.9 | 9.0 | 5.4 | 58.4 | 56.3 | 79.4 | 70.8 |
| PCDC | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| INS | 31.2 | 30.1 | 70.0 | 68.0 | 26.2 | 21.0 | 109.2 | 105.2 | 89.0 | 85.7 |
| OJP | 242.6 | 21.1 | 96.6 | 105.1 | 90.0 | 33.3 | 182.8 | 120.4 | 164.8 | 216.7 |
| Forfeiture Fund | 120.0 | 75.0 | 161.0 | 150.0 | 0.0 | 0.0 | 326.0 | 145.5 | 337.0 | 281.0 |
| INTERPOL | 0.6 | 0.6 | 0.8 | 0.8 | 0.8 | 0.6 | 1.1 | 1.0 | 1.1 | 1.0 |
| Inspector General | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 0.4 | 1.2 | 1.0 |
| | 1,454.9 | 1,053.9 | 1,597.5 | 1,566.8 | 278.9 | 155.6 | 2,199.6 | 1,819.3 | 2,469.1 | 2,316.7 |
| Department of Treasury | | | | | | | | | | |
| Customs | 459.5 | 488.3 | 425.8 | 385.5 | 15.2 | 10.9 | 444.0 | 435.0 | 441.5 | 431.9 |
| IRS | 66.6 | 66.6 | 63.9 | 63.9 | 0.0 | 0.0 | 68.3 | 68.3 | 55.6 | 55.6 |
| BATF | 11.3 | 11.1 | 8.2 | 8.0 | 0.0 | 0.0 | 8.8 | 8.6 | 1.2 | 1.2 |
| Payments to Puerto Rico | 7.8 | 7.8 | 7.8 | 7.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | 545.2 | 573.8 | 505.7 | 465.3 | 15.2 | 10.9 | 521.1 | 511.9 | 498.3 | 488.7 |
| Department of Transportation | | | | | | | | | | |
| Coast Guard | 557.1 | 521.8 | 513.9 | 482.6 | 53.2 | 17.7 | 632.9 | 601.5 | 689.9 | 654.1 |
| FAA | 1.0 | 1.0 | 6.3 | 6.3 | 0.0 | 0.0 | 4.3 | 4.3 | 21.7 | 21.7 |
| NHTSA | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.2 | 9.0 | 3.6 |
| | 558.1 | 522.8 | 520.2 | 488.9 | 53.2 | 17.7 | 637.6 | 606.0 | 720.6 | 679.4 |
| Department of State | | | | | | | | | | |
| INM | 118.4 | 59.6 | 98.8 | 95.0 | 0.0 | 0.0 | 101.0 | 97.0 | 115.0 | 112.0 |
| AID (Direct) | 12.3 | 13.6 | 14.3 | 13.7 | 0.0 | 0.0 | 17.9 | 27.0 | 13.2 | 25.7 |
| USIA | 2.0 | 1.8 | 1.0 | 1.0 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| SAE | 0.0 | 0.0 | 0.0 | 0.0 | 5.0 | 4.0 | 5.0 | 4.0 | 0.0 | 0.0 |
| | 132.8 | 75.0 | 114.1 | 109.7 | 5.0 | 4.0 | 124.9 | 128.9 | 129.2 | 138.7 |

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

AS
File name: ROLLUP
By Agency

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of Agriculture | | | | | | | | | | |
| Agriculture Research Service | 1.4 | 1.4 | 1.3 | 1.3 | 0.0 | 0.0 | 1.3 | 1.3 | 1.3 | 1.3 |
| U.S. Forest Service | 3.2 | 3.2 | 5.2 | 5.2 | 0.0 | 0.0 | 5.2 | 5.2 | 5.3 | 5.3 |
| | 4.6 | 4.6 | 6.5 | 6.5 | 0.0 | 0.0 | 6.5 | 6.5 | 7 | 6.6 |
| Department of Interior | | | | | | | | | | |
| Bureau of Land Management | 1.0 | 1.0 | 1.5 | 1.5 | 0.0 | 0.0 | 1.3 | 1.3 | 6.8 | 6.8 |
| U. S. Park Service | 1.2 | 1.2 | 1.2 | 1.2 | 0.0 | 0.0 | 1.2 | 1.2 | 7.6 | 7.6 |
| Bureau of Indian Affairs | 12.4 | 7.0 | 6.5 | 6.8 | 0.0 | 0.0 | 6.8 | 8.6 | 9.9 | 11.8 |
| Fish and Wildlife Service | 0.4 | 0.4 | 0.4 | 0.4 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 |
| | 15.0 | 9.6 | 9.6 | 9.8 | 0.0 | 0.0 | 9.7 | 11.5 | 26.7 | 26.6 |
| Department of Defense | | | | | | | | | | |
| Interdiction | 405.3 | 166.1 | 94.7 | 257.9 | 0.0 | 0.0 | 308.3 | 303.1 | 317.6 | 312.9 |
| Demand reduction | 98.7 | 91.9 | 105.9 | 100.5 | 0.0 | 0.0 | 112.0 | 107.0 | 117.5 | 112.4 |
| | 504.0 | 256.0 | 200.6 | 358.4 | 0.0 | 0.0 | 420.3 | 410.1 | 435.1 | 425.3 |
| Department of HHS | | | | | | | | | | |
| ADAMHA | 503.4 | 434.4 | 520.8 | 508.9 | 283.0 | 209.5 | 890.8 | 732.6 | 986.0 | 940.5 |
| IHS | 4.8 | 4.8 | 16.2 | 16.2 | 0.0 | 0.0 | 18.7 | 18.7 | 18.7 | 18.7 |
| FDA | 1.6 | 1.6 | 1.6 | 1.6 | 5.0 | 4.4 | 6.7 | 4.7 | 1.8 | 3.8 |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 30.0 | 3.0 | 30.0 | 3.0 | 30.0 | 29.0 |
| | 509.8 | 440.8 | 538.6 | 526.7 | 318.0 | 216.9 | 946.2 | 759.0 | 1,036.5 | 992.0 |
| Department of Education | 203.0 | 41.8 | 229.8 | 139.8 | 108.0 | 13.3 | 354.5 | 210.9 | 391.6 | 357.7 |
| Department of Labor | 5.8 | 5.8 | 3.1 | 1.8 | 2.0 | 1.2 | 5.7 | 3.4 | 3.7 | 2.2 |
| ACTION | 7.8 | 7.8 | 5.9 | 3.8 | 2.0 | 1.2 | 7.9 | 5.0 | 5.9 | 3.8 |
| White House Conference | 2.0 | 0.7 | 2.5 | 3.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Veterans Administration | 83.2 | 83.0 | 88.5 | 86.2 | 0.0 | 0.0 | 93.9 | 93.6 | 96.5 | 96.1 |
| TOTAL FEDERAL DRUG PROGRAM | 4,026.3 | 3,075.6 | 3,822.5 | 3,768.4 | 785.8 | 423.3 | 5,331.4 | 4,568.7 | 5,965.9 | 5,542.8 |

# SPENDING BY STRATEGY

BJI
File name: ROLLUP
By Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Office of National Drug Control Policy | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| INTERDICTION | | | | | | | | | | | | |
| Coast Guard | 227.5 | 227.4 | 328.9 | 328.9 | 359.9 | 359.9 | 508.2 | 508.2 | 506.6 | 506.7 | 397.8 | 441.0 |
| DOJ Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 26.0 | 20.0 |
| Customs | 122.0 | 122.2 | 126.0 | 121.3 | 103.6 | 99.2 | 183.7 | 133.7 | 245.3 | 208.6 | 239.7 | 213.4 |
| Customs/Asset Forfeiture | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 7.7 | 7.5 |
| DOD | 0.0 | 0.0 | 4.9 | 4.0 | 9.7 | 8.0 | 14.6 | 13.0 | 56.8 | 44.0 | 105.7 | 73.7 |
| INS | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.4 | 0.3 | 0.4 | 0.4 | 0.7 | 0.7 |
| Payments to Puerto Rico | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| FAA | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal | 349.7 | 349.8 | 458.0 | 454.4 | 473.4 | 467.3 | 706.9 | 655.2 | 807.2 | 759.6 | 777.6 | 756.3 |
| INVESTIGATIONS | | | | | | | | | | | | |
| DEA | 126.2 | 126.2 | 140.5 | 137.3 | 143.7 | 146.6 | 178.0 | 171.8 | 211.1 | 206.6 | 252.9 | 236.0 |
| FBI | 7.7 | 7.7 | 36.2 | 36.2 | 131.4 | 131.4 | 94.4 | 94.4 | 98.7 | 98.7 | 98.5 | 92.8 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| U.S. Marshals | 3.2 | 3.0 | 3.7 | 3.5 | 4.0 | 3.8 | 5.3 | 5.0 | 7.4 | 7.0 | 6.8 | 6.5 |
| INS | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 5.5 | 5.5 |
| IRS | 34.6 | 34.6 | 43.2 | 43.2 | 49.4 | 49.4 | 56.3 | 56.3 | 60.2 | 60.2 | 59.6 | 59.6 |
| Customs | 11.4 | 11.4 | 13.9 | 13.6 | 30.4 | 30.2 | 39.6 | 40.2 | 44.7 | 41.7 | 52.2 | 46.5 |
| BATF | 0.0 | 0.0 | 1.5 | 0.5 | 4.6 | 2.9 | 8.3 | 8.1 | 9.5 | 9.3 | 7.5 | 7.3 |
| U. S. Forest Service | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.4 | 0.4 | 0.3 | 0.3 |
| Bureau of Land Management | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.4 |
| U.S. Park Service | 0.1 | 0.1 | 0.2 | 0.2 | 0.5 | 0.5 | 0.7 | 0.7 | 0.8 | 0.8 | 0.2 | 0.2 |
| Bureau of Indian Affairs | 0.7 | 0.7 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 1.9 | 0.8 | 1.7 | 1.7 |
| Subtotal | 181.9 | 181.7 | 242.1 | 237.5 | 365.1 | 365.8 | 383.5 | 377.5 | 434.8 | 425.6 | 483.5 | 456.8 |
| INTERNATIONAL | | | | | | | | | | | | |
| DEA | 31.0 | 31.0 | 34.3 | 31.6 | 36.9 | 37.7 | 42.8 | 41.3 | 51.0 | 48.0 | 47.7 | 42.8 |
| FBI | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 1.0 |
| U.S. Marshals | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 |
| INTERPOL | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 |
| INM | 34.7 | 28.4 | 36.7 | 42.3 | 36.7 | 36.6 | 41.2 | 33.3 | 50.2 | 51.6 | 55.1 | 58.3 |
| AID (Direct) | 0.0 | 0.0 | 15.7 | 1.0 | 9.2 | 5.8 | 10.6 | 7.4 | 6.7 | 4.2 | 23.5 | 15.7 |
| USIA | 1.0 | 0.5 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| State (S&E) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal | 66.8 | 59.9 | 87.8 | 75.9 | 83.9 | 81.1 | 95.8 | 83.2 | 109.2 | 105.1 | 148.7 | 139.2 |



23-163 0 - 90 - 4

BJ1
File name: ROLLUP
By Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| RESEARCH AND DEVELOPMENT | | | | | | | | | | | | |
| DEA | 1.4 | 2.4 | 1.8 | 2.7 | 3.9 | 4.9 | 2.9 | 2.9 | 2.2 | 2.2 | 1.5 | 2.5 |
| PCOC | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 1.6 | 1.5 | 2.2 | 2.0 | 1.0 | 1.3 |
| IRS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| OJP | 0.0 | 0.0 | 0.2 | 0.1 | 2.2 | 1.0 | 0.3 | 1.4 | 0.9 | 0.6 | 2.7 | 2.1 |
| Customs | 1.8 | 1.8 | 1.6 | 1.6 | 1.5 | 1.5 | 1.2 | 1.2 | 1.5 | 1.4 | 1.3 | 1.2 |
| Coast Guard | 0.3 | 0.3 | 0.3 | 0.3 | 0.2 | 0.2 | 0.4 | 0.4 | 1.5 | 1.5 | 3.6 | 3.3 |
| Agriculture Resch. Ser. | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.3 | 1.3 |
| U. S. Forest Service | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.0 | 0.0 |
| Subtotal | 4.9 | 5.9 | 5.4 | 6.2 | 9.4 | 9.2 | 7.9 | 8.8 | 9.9 | 9.4 | 11.3 | 11.7 |
| REGULATORY AND COMPLIANCE | | | | | | | | | | | | |
| DEA | 17.0 | 16.8 | 20.3 | 18.7 | 25.0 | 24.4 | 21.9 | 21.1 | 25.0 | 23.5 | 12.3 | 11.5 |
| DOJ-Inspector General | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| IRS | 0.4 | 0.4 | 0.8 | 0.8 | 0.7 | 0.7 | 0.8 | 0.8 | 0.7 | 0.7 | 1.0 | 1.0 |
| U. S. Forest Service | 0.1 | 0.1 | 0.3 | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 0.2 | 0.2 | 0.6 | 0.6 |
| FDA | 1.4 | 1.4 | 0.8 | 0.8 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 1.6 | 1.6 |
| Subtotal | 18.9 | 18.7 | 22.2 | 20.5 | 26.7 | 26.1 | 23.8 | 23.1 | 26.6 | 25.1 | 15.5 | 14.7 |
| Subtotal, Drug Law Enforcement | 800.0 | 805.7 | 1,020.5 | 981.3 | 1,207.7 | 1,184.1 | 1,498.7 | 1,415.3 | 1,769.7 | 1,676.7 | 1,875.4 | 1,807.4 |
| DRUG ABUSE PREVENTION | | | | | | | | | | | | |
| Drug Czar | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of HHS | | | | | | | | | | | | |
| Alcohol, Drug Abuse & Mental Health Administration | 95.0 | 92.7 | 79.8 | 80.9 | 86.2 | 85.2 | 97.3 | 97.1 | 108.7 | 108.2 | 121.9 | 120.2 |
| Other HHS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of Defense | 21.2 | 15.5 | 36.2 | 30.9 | 46.4 | 42.1 | 49.8 | 47.1 | 63.0 | 57.8 | 63.4 | 60.9 |
| Department of Education | 2.9 | 2.9 | 2.9 | 3.5 | 2.9 | 2.1 | 2.9 | 2.7 | 3.0 | 3.7 | 2.9 | 2.3 |
| Department of Labor | 3.4 | 3.4 | 1.4 | 1.4 | 0.6 | 0.6 | 0.4 | 0.2 | 0.4 | 0.3 | 0.1 | 0.3 |
| Department of Interior (BIA) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| ACTION | 2.5 | 2.5 | 6.8 | 6.8 | 6.9 | 6.9 | 6.8 | 6.8 | 6.9 | 6.9 | 6.9 | 6.9 |

BJ1
File name: ROLLUP
By Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of State (AID) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.1 | 1.9 | 0.9 |
| Department of Justice (DEA) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.4 | 0.4 |
| Department of Justice (OJP) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.3 | 2.4 |
| Department of Transport. (NHTSA) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of Transportation (FAA) | 0.4 | 0.4 | 0.2 | 0.2 | 0.4 | 0.4 | 0.5 | 0.5 | 0.4 | 0.4 | 0.5 | 0.5 |
| White House Conference | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Drug Abuse Prevention | 125.2 | 117.3 | 127.2 | 123.6 | 143.3 | 137.3 | 157.7 | 154.4 | 183.7 | 177.4 | 201.3 | 196.8 |
| DRUG ABUSE TREATMENT | | | | | | | | | | | | |
| Drug Czar | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of HHS<br>Alcohol, Drug Abuse & Mental Health Administration | 144.0 | 140.6 | 81.2 | 83.3 | 96.8 | 96.5 | 96.1 | 95.9 | 101.9 | 102.5 | 97.5 | 97.2 |
| Indian Health Service | 1.5 | 1.5 | 1.6 | 1.7 | 2.1 | 2.0 | 2.3 | 2.2 | 2.4 | 2.4 | 2.4 | 2.4 |
| Department of Defense | 12.4 | 9.1 | 21.4 | 18.3 | 23.3 | 21.8 | 24.1 | 23.1 | 18.5 | 19.2 | 19.6 | 18.9 |
| Department of Justice (Prisons) | 2.9 | 2.8 | 2.9 | 2.8 | 2.8 | 2.6 | 2.7 | 2.5 | 3.1 | 3.0 | 3.3 | 3.2 |
| Department of Justice (OJP) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.3 |
| Department of Interior (BIA) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Veterans Administration | 52.0 | 51.8 | 55.8 | 55.6 | 60.5 | 60.3 | 63.3 | 61.1 | 66.4 | 64.3 | 68.4 | 68.1 |
| Subtotal, Drug Abuse Treatment | 212.8 | 205.8 | 162.9 | 161.7 | 185.5 | 183.2 | 188.5 | 184.8 | 192.5 | 191.4 | 192.4 | 190.1 |
| TOTAL, FEDERAL DRUG SUMMARY | 1,138.0 | 1,128.8 | 1,310.6 | 1,266.7 | 1,536.6 | 1,504.6 | 1,844.8 | 1,754.5 | 2,145.9 | 2,045.5 | 2,269.1 | 2,192.3 |

09-Feb-89

BJI
File name: ROLLUP
By Strategy

# FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Office of National Drug Control Policy | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.9 | 1.2 | 0.9 | 4.8 | 3.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 45.3 | 0.0 |
| **INTERDICTION** | | | | | | | | | | |
| Coast Guard | 553.0 | 517.8 | 509.8 | 478.5 | 53.2 | 17.7 | 628.9 | 597.5 | 685.4 | 649.6 |
| DOJ Forfeiture Fund | 73.0 | 28.0 | 85.0 | 74.0 | 0.0 | 0.0 | 206.0 | 90.3 | 209.0 | 153.0 |
| Customs | 367.1 | 398.1 | 317.5 | 286.7 | 15.2 | 10.9 | 334.9 | 327.7 | 315.3 | 308.6 |
| Customs/Asset Forfeiture | 18.0 | 10.0 | 10.0 | 8.9 | 0.0 | 0.0 | 10.0 | 10.0 | 10.0 | 10.0 |
| DOD | 405.3 | 164.1 | 96.7 | 257.9 | 0.0 | 0.0 | 308.3 | 303.1 | 317.6 | 312.9 |
| INS | 17.2 | 16.1 | 17.5 | 16.4 | 7.0 | 5.6 | 42.0 | 39.3 | 29.8 | 27.8 |
| Payments to Puerto Rico | 7.8 | 7.8 | 7.8 | 7.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 15.3 | 11.5 |
| FAA | 0.0 | 0.0 | 0.7 | 0.7 | 0.0 | 0.0 | 0.0 | 0.0 | 6.9 | 6.9 |
| Subtotal | 1,441.4 | 1,141.9 | 1,043.0 | 1,130.9 | 75.4 | 34.2 | 1,530.1 | 1,367.9 | 1,589.3 | 1,480.3 |
| **INVESTIGATIONS** | | | | | | | | | | |
| DEA | 325.1 | 276.5 | 327.3 | 328.0 | 11.6 | 8.7 | 368.5 | 335.8 | 346.2 | 332.0 |
| FBI | 91.0 | 85.4 | 114.9 | 111.6 | 14.8 | 11.8 | 125.4 | 127.4 | 88.5 | 84.7 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 152.0 | 114.0 |
| U.S. Marshals | 8.8 | 8.4 | 11.2 | 10.6 | 0.9 | 0.7 | 15.1 | 14.7 | 15.4 | 15.2 |
| INS | 9.8 | 9.8 | 17.1 | 17.1 | 6.9 | 5.5 | 21.4 | 21.4 | 13.4 | 13.4 |
| IRS | 59.7 | 59.7 | 46.3 | 46.3 | 0.0 | 0.0 | 48.6 | 48.6 | 35.1 | 35.1 |
| Customs | 63.1 | 68.4 | 75.1 | 67.8 | 0.0 | 0.0 | 75.1 | 73.5 | 92.2 | 89.5 |
| BATF | 11.3 | 11.1 | 8.2 | 8.0 | 0.0 | 0.0 | 8.8 | 8.6 | 1.2 | 1.2 |
| U. S. Forest Service | 0.3 | 0.3 | 0.4 | 0.4 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 |
| Bureau of Land Management | 0.5 | 0.5 | 0.9 | 0.9 | 0.0 | 0.0 | 0.7 | 0.7 | 5.2 | 5.2 |
| U.S. Park Service | 1.2 | 1.2 | 1.2 | 1.2 | 0.0 | 0.0 | 1.2 | 1.2 | 7.6 | 7.6 |
| Bureau of Indian Affairs | 3.6 | 2.2 | 2.3 | 2.3 | 0.0 | 0.0 | 2.4 | 2.5 | 3.6 | 4.3 |
| Subtotal | 574.3 | 523.4 | 606.9 | 594.3 | 34.2 | 26.8 | 667.6 | 634.8 | 760.8 | 702.6 |
| **INTERNATIONAL** | | | | | | | | | | |
| DEA | 91.1 | 72.1 | 97.4 | 92.5 | 13.1 | 9.8 | 96.8 | 88.2 | 113.0 | 106.6 |
| FBI | 1.3 | 1.3 | 0.5 | 0.5 | 0.0 | 0.0 | 0.4 | 0.4 | 0.5 | 0.4 |
| U.S. Marshals | 0.3 | 0.3 | 0.5 | 0.4 | 0.1 | 0.1 | 0.7 | 0.6 | 0.5 | 0.5 |
| INTERPOL | 0.6 | 0.6 | 0.8 | 0.8 | 0.8 | 0.6 | 1.1 | 1.0 | 1.1 | 1.0 |
| INM | 118.4 | 59.6 | 98.8 | 95.0 | 0.0 | 0.0 | 101.0 | 97.0 | 115.0 | 112.0 |
| AID (Direct) | 7.1 | 11.3 | 9.9 | 9.9 | 0.0 | 0.0 | 12.7 | 21.6 | 10.6 | 20.8 |
| USIA | 2.0 | 1.8 | 1.0 | 1.0 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| State (SSE) | 0.0 | 0.0 | 0.0 | 0.0 | 5.0 | 4.0 | 5.0 | 4.0 | 0.0 | 0.0 |
| Subtotal | 220.9 | 147.0 | 208.8 | 200.1 | 19.0 | 14.5 | 218.7 | 213.7 | 241.7 | 242.3 |

FBI: Contacts drug along w/ DE (since 1982)

09-Feb-89

BJI
File name: ROLLUP
By Strategy

# FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| **PROSECUTION** | | | | | | | | | | |
| U.S. Attorneys | 74.2 | 69.8 | 80.7 | 79.8 | 55.9 | 49.2 | 141.4 | 139.9 | 113.2 | 112.2 |
| OCDE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 47.6 | 35.7 |
| Criminal Div. | 3.3 | 3.0 | 9.4 | 9.4 | 1.0 | 0.9 | 10.7 | 10.6 | 10.1 | 10.2 |
| Tax Div. | 2.0 | 2.0 | 2.2 | 2.1 | 0.0 | 0.0 | 2.2 | 2.1 | 0.8 | 0.7 |
| U.S. Marshals | 56.7 | 53.9 | 79.9 | 75.8 | 7.0 | 5.6 | 108.1 | 105.3 | 135.1 | 132.7 |
| IRS | 5.8 | 5.8 | 14.3 | 14.3 | 0.0 | 0.0 | 15.0 | 15.0 | 15.2 | 15.2 |
| Subtotal | 142.8 | 134.5 | 186.5 | 181.4 | 63.9 | 55.7 | 277.4 | 272.9 | 322.0 | 306.7 |
| **CORRECTIONS** | | | | | | | | | | |
| Prisons | 300.4 | 259.2 | 410.2 | 406.3 | 43.0 | 4.3 | 574.4 | 493.8 | 657.7 | 608.2 |
| Support of Prisoners | 27.9 | 24.0 | 53.3 | 47.9 | 9.0 | 5.4 | 58.4 | 56.3 | 79.4 | 70.8 |
| INS | 4.0 | 4.0 | 34.5 | 33.6 | 12.3 | 9.8 | 44.6 | 43.3 | 44.6 | 43.3 |
| Subtotal | 332.3 | 287.2 | 498.0 | 487.8 | 64.3 | 19.6 | 677.4 | 593.4 | 781.7 | 722.3 |
| **INTELLIGENCE** | | | | | | | | | | |
| DEA | 36.2 | 33.2 | 34.4 | 32.7 | 5.3 | 4.0 | 31.4 | 28.6 | 51.5 | 48.9 |
| FBI | 4.8 | 4.5 | 9.5 | 9.2 | 0.2 | 0.2 | 3.5 | 3.5 | 2.4 | 2.3 |
| INS | 0.2 | 0.2 | 0.9 | 0.9 | 0.0 | 0.0 | 0.8 | 0.8 | 0.8 | 0.8 |
| Customs | 3.7 | 4.1 | 8.3 | 7.5 | 0.0 | 0.0 | 8.3 | 8.1 | 8.3 | 8.1 |
| FAA | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 0.1 | 4.1 | 4.1 |
| U.S. Forest Service | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 |
| Subtotal | 45.0 | 42.1 | 53.3 | 50.5 | 5.5 | 4.1 | 44.2 | 41.2 | 67.2 | 64.3 |
| **STATE AND LOCAL ASSISTANCE** | | | | | | | | | | |
| DEA | 13.2 | 11.5 | 11.4 | 10.8 | 0.0 | 0.0 | 13.8 | 12.6 | 14.4 | 13.7 |
| DOJ Forfeiture Fund | 47.0 | 47.0 | 76.0 | 76.0 | 0.0 | 0.0 | 120.0 | 55.2 | 128.0 | 128.0 |
| Customs Forfeiture Fund | 6.5 | 6.5 | 11.2 | 11.2 | 0.0 | 0.0 | 12.0 | 12.0 | 12.0 | 12.0 |
| NHTSA | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.2 | 4.0 | 1.6 |
| OJP | 214.6 | 13.3 | 71.5 | 79.6 | 90.0 | 33.3 | 141.8 | 89.5 | 107.1 | 169.0 |
| U. S. Forest Service | 1.9 | 1.9 | 2.0 | 2.0 | 0.0 | 0.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Bureau of Land Management | 0.6 | 0.6 | 0.6 | 0.6 | 0.0 | 0.0 | 0.6 | 0.6 | 1.6 | 1.6 |
| Bureau of Indian Affairs | 5.4 | 3.3 | 3.4 | 3.5 | 0.0 | 0.0 | 3.6 | 3.8 | 5.4 | 6.4 |
| Fish and Wildlife Service | 0.4 | 0.4 | 0.4 | 0.4 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 |
| Subtotal | 289.5 | 84.4 | 176.5 | 184.0 | 90.0 | 33.3 | 294.6 | 176.3 | 274.9 | 334.7 |

09-Feb-89

BJI
File name: ROLLUP
By Strategy

## FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUPPORT
(Budget Authority and Outlays in millions)

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| **RESEARCH AND DEVELOPMENT** | | | | | | | | | | |
| DEA | 4.3 | 3.4 | 3.2 | 3.1 | 0.0 | 0.0 | 2.7 | 2.5 | 3.0 | 2.9 |
| PCDC | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| IRS | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 |
| OJP | 4.7 | 3.8 | 9.6 | 9.0 | 0.0 | 0.0 | 12.5 | 10.9 | 12.0 | 11.1 |
| Customs | 1.1 | 1.2 | 3.7 | 3.4 | 0.0 | 0.0 | 3.7 | 3.7 | 3.7 | 3.7 |
| Coast Guard | 4.1 | 4.0 | 4.1 | 4.1 | 0.0 | 0.0 | 4.0 | 4.0 | 4.5 | 4.5 |
| Agriculture Resch. Ser. | 1.4 | 1.4 | 1.3 | 1.3 | 0.0 | 0.0 | 1.3 | 1.3 | 1.3 | 1.3 |
| U. S. Forest Service | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 |
| Subtotal | 15.6 | 13.8 | 21.9 | 20.9 | 0.0 | 0.0 | 24.7 | 22.9 | 25.0 | 24.0 |
| **REGULATORY AND COMPLIANCE** | | | | | | | | | | |
| DEA | 15.3 | 14.1 | 16.9 | 16.1 | 0.0 | 0.0 | 19.1 | 17.4 | 20.9 | 19.8 |
| DOJ-Inspector General | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 0.4 | 1.2 | 1.0 |
| IRS | 1.1 | 1.1 | 3.3 | 3.3 | 0.0 | 0.0 | 4.7 | 4.7 | 5.2 | 5.2 |
| U. S. Forest Service | 1.0 | 1.0 | 2.7 | 2.7 | 0.0 | 0.0 | 2.6 | 2.6 | 2.7 | 2.7 |
| FDA | 1.6 | 1.6 | 1.6 | 1.6 | 5.0 | 4.4 | 6.7 | 4.7 | 1.8 | 3.8 |
| Subtotal | 19.0 | 17.8 | 24.5 | 23.7 | 5.0 | 4.4 | 33.7 | 29.8 | 31.8 | 32.5 |
| Subtotal, Drug Law Enforcement | 3,080.0 | 2,392.1 | 2,817.4 | 2,873.6 | 358.5 | 193.3 | 3,769.6 | 3,353.8 | 4,143.8 | 3,912.8 |
| **DRUG ABUSE PREVENTION** | | | | | | | | | | |
| Drug Czar | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.9 | 1.2 | 0.9 | 4.0 | 3.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 45.3 | 0.0 |
| Department of HHS<br>Alcohol, Drug Abuse & Mental Health Administration | 226.0 | 195.5 | 259.7 | 254.2 | 108.0 | 80.0 | 428.7 | 350.0 | 445.0 | 442.5 |
| Other HHS | 0.0 | 0.0 | 0.0 | 0.0 | 30.0 | 3.0 | 30.0 | 3.0 | 30.0 | 29.0 |
| Department of Defense | 77.8 | 72.0 | 83.8 | 79.4 | 0.0 | 0.0 | 89.0 | 85.0 | 96.5 | 90.1 |
| Department of Education | 203.0 | 41.8 | 229.8 | 139.8 | 108.0 | 13.3 | 354.5 | 210.9 | 391.6 | 357.7 |
| Department of Labor | 5.8 | 5.8 | 3.1 | 1.8 | 2.0 | 1.2 | 5.7 | 3.4 | 3.7 | 2.2 |
| Department of Interior (BIA) | 1.8 | 1.5 | 0.8 | 1.0 | 0.0 | 0.0 | 0.8 | 0.8 | 0.6 | 0.6 |
| ACTION | 7.8 | 7.8 | 5.9 | 3.8 | 2.0 | 1.2 | 7.9 | 5.0 | 5.9 | 3.8 |

09-Feb-89

BJI
File name: ROLLUP
By Strategy

# FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | 1987 | | 1988 | | 1989 Drug Bill Supplemental | | Total 1989 Enacted | | 1990 President's February Budget | |
|---|---|---|---|---|---|---|---|---|---|---|
| | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of State (AID) | 5.2 | 2.3 | 4.5 | 3.8 | 0.0 | 0.0 | 5.2 | 5.4 | 2.6 | 4.9 |
| Department of Justice (DEA) | 0.9 | 0.9 | 1.9 | 1.8 | 0.0 | 0.0 | 2.2 | 2.1 | 2.2 | 2.1 |
| Department of Justice (OJP) | 3.7 | 3.2 | 7.4 | 7.0 | 0.0 | 0.0 | 11.5 | 10.0 | 45.5 | 20.2 |
| Department of Transport. (NHTSA) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 5.0 | 2.0 |
| Department of Transportation (FAA) | 0.9 | 0.9 | 5.5 | 5.5 | 0.0 | 0.0 | 4.2 | 4.2 | 10.7 | 10.7 |
| White House Conference | 2.0 | 0.7 | 2.5 | 3.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Drug Abuse Prevention | 532.9 | 332.4 | 604.8 | 501.0 | 251.2 | 99.6 | 940.8 | 680.7 | 1,086.7 | 968.8 |
| DRUG ABUSE TREATMENT | | | | | | | | | | |
| Drug Czar | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.9 | 1.2 | 0.9 | 4.0 | 3.0 |
| Special Forfeiture Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 45.3 | 0.0 |
| Department of HHS Alcohol, Drug Abuse & Mental Health Administration | 279.4 | 238.9 | 261.1 | 254.7 | 175.0 | 129.5 | 462.1 | 382.6 | 541.0 | 498.0 |
| Indian Health Service | 4.8 | 4.8 | 16.2 | 16.2 | 0.0 | 0.0 | 18.7 | 18.7 | 18.7 | 18.7 |
| Department of Defense | 20.9 | 19.9 | 22.1 | 21.1 | 0.0 | 0.0 | 23.0 | 22.0 | 23.0 | 22.3 |
| Department of Justice (Prisons) | 3.8 | 3.7 | 4.3 | 4.1 | 0.0 | 0.0 | 5.1 | 5.0 | 6.3 | 6.2 |
| Department of Justice (OJP) | 19.6 | 0.8 | 8.1 | 9.5 | 0.0 | 0.0 | 17.0 | 10.0 | 0.2 | 16.4 |
| Department of Interior (BIA) | 1.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.5 | 0.3 | 0.5 |
| Veterans Administration | 83.2 | 83.0 | 88.5 | 88.2 | 0.0 | 0.0 | 93.9 | 93.6 | 96.5 | 96.1 |
| Subtotal, Drug Abuse Treatment | 413.4 | 351.1 | 400.3 | 393.8 | 176.2 | 130.4 | 621.0 | 534.3 | 735.3 | 661.2 |
| TOTAL, FEDERAL DRUG SUMMARY | 4,026.3 | 3,075.6 | 3,822.5 | 3,768.4 | 785.8 | 423.3 | 5,331.4 | 4,568.7 | 5,965.9 | 5,542.8 |

941
621
1562
5331

2770

# SPENDING BY AGENCY BY STRATEGY

AE1
File Name: ROLLUP
By Agency by Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Office of National Drug Control Policy | Law Enforce. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Treatment | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Special Forfeiture Fund | Law Enforce. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Treatment | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Department of Justice DEA | Investigations | 126.2 | 126.2 | 140.5 | 137.3 | 143.7 | 146.6 | 178.0 | 171.8 | 211.1 | 206.6 | 252.9 | 236.0 |
| | International | 31.0 | 31.0 | 34.3 | 31.6 | 36.9 | 37.7 | 42.8 | 41.3 | 51.0 | 48.0 | 67.7 | 62.8 |
| | Intelligence | 20.9 | 20.8 | 23.0 | 18.0 | 21.5 | 21.9 | 23.6 | 22.8 | 25.4 | 23.9 | 25.0 | 23.3 |
| | S & L Assist. | 21.6 | 21.6 | 19.2 | 16.3 | 23.9 | 24.5 | 22.6 | 21.8 | 29.2 | 27.5 | 12.5 | 11.2 |
| | R & D | 1.4 | 2.4 | 1.8 | 2.7 | 3.9 | 4.9 | 2.9 | 2.9 | 2.2 | 2.2 | 1.5 | 2.5 |
| | Reg. & Comply | 17.0 | 16.8 | 20.3 | 18.7 | 25.0 | 24.4 | 21.9 | 21.1 | 25.0 | 23.5 | 12.3 | 11.5 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.4 | 0.4 |
| | | 216.1 | 216.8 | 239.1 | 224.6 | 254.9 | 259.9 | 291.9 | 281.8 | 344.0 | 331.8 | 372.3 | 347.7 |
| FBI | Investigations | 7.7 | 7.7 | 38.2 | 38.2 | 131.4 | 131.4 | 94.4 | 94.4 | 98.7 | 98.7 | 96.5 | 92.8 |
| | International | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 1.0 |
| | Intelligence | 0.6 | 0.6 | 2.0 | 2.0 | 5.4 | 5.4 | 5.0 | 5.0 | 5.2 | 5.2 | 5.0 | 4.8 |
| | | 8.3 | 8.3 | 40.2 | 40.2 | 136.9 | 136.9 | 99.3 | 99.3 | 103.9 | 103.9 | 102.5 | 98.6 |
| OCDE | Investigations | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Interdiction | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Prosecution | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Criminal Div. | Prosecution | 1.6 | 1.5 | 1.9 | 1.8 | 1.8 | 1.7 | 1.9 | 1.8 | 2.7 | 2.5 | 2.7 | 2.6 |
| Tax Div. | Prosecution | 0.0 | 0.0 | 0.0 | 0.0 | 0.8 | 0.8 | 0.8 | 0.8 | 1.6 | 1.6 | 2.0 | 2.0 |
| U.S. Attorneys | Prosecution | 19.5 | 19.5 | 20.9 | 20.4 | 32.7 | 32.0 | 47.7 | 46.7 | 54.8 | 53.7 | 57.3 | 53.3 |
| U.S. Marshals | Investigations | 3.2 | 3.0 | 3.7 | 3.5 | 4.0 | 3.8 | 5.3 | 5.0 | 7.4 | 7.0 | 6.8 | 6.5 |
| | International | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 |
| | Prosecution | 23.1 | 22.0 | 25.6 | 24.4 | 27.0 | 25.7 | 30.4 | 29.0 | 40.6 | 38.5 | 45.2 | 42.8 |
| | | 26.3 | 25.0 | 29.4 | 27.9 | 31.1 | 29.5 | 36.0 | 34.2 | 48.1 | 45.7 | 52.2 | 49.5 |

AE1
File Name: ROLLUP
By Agency by Strategy

09-Feb-89

## FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Prisons | Corrections | 76.8 | 80.3 | 96.5 | 85.0 | 111.7 | 99.8 | 118.2 | 116.8 | 175.7 | 159.6 | 218.4 | 226.6 |
| | Treatment | 2.9 | 2.8 | 2.9 | 2.8 | 2.8 | 2.6 | 2.7 | 2.5 | 3.1 | 3.0 | 3.3 | 3.2 |
| | | 79.7 | 83.1 | 99.4 | 87.8 | 114.5 | 102.4 | 120.9 | 119.3 | 178.8 | 162.6 | 221.7 | 227.8 |
| Support of Prisoners | Prosecution | 5.9 | 5.4 | 8.0 | 7.3 | 13.1 | 12.0 | 16.4 | 15.0 | 19.5 | 17.9 | 21.1 | 19.3 |
| PCCC | R & D | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 1.6 | 1.5 | 2.2 | 2.0 | 1.0 | 1.3 |
| IRS | Interdiction | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.4 | 0.3 | 0.4 | 0.4 | 0.7 | 0.7 |
| | Investigations | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 5.5 | 5.5 |
| | Intelligence | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 | 0.3 |
| | Corrections | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | R & D | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 0.3 | 0.2 | 0.3 | 0.3 | 0.4 | 0.4 | 0.5 | 0.5 | 0.5 | 0.5 | 6.5 | 6.5 |
| OJP | S & L Assist. | 4.5 | 14.7 | 4.2 | 7.8 | 6.7 | 6.2 | 7.2 | 7.0 | 12.0 | 7.5 | 12.7 | 8.5 |
| | R & D | 0.0 | 0.0 | 0.2 | 0.1 | 2.2 | 1.0 | 0.3 | 1.4 | 0.9 | 0.6 | 2.7 | 2.1 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.3 | 2.4 |
| | Treatment | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.3 |
| | | 4.5 | 14.7 | 4.4 | 8.0 | 8.8 | 7.1 | 7.4 | 8.4 | 12.9 | 8.1 | 19.9 | 13.3 |
| Forfeiture Fund | S&L Assist. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 17.0 | 17.0 |
| | Other Law Enf. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 26.0 | 20.0 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 43.0 | 37.0 |
| INTERPOL | International | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 |
| Inspector General | Reg. & Comply | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| SubTotal, Department of Justice | | 362.2 | 374.5 | 443.5 | 418.3 | 595.3 | 583.0 | 624.7 | 603.4 | 769.2 | 750.5 | 902.5 | 859.0 |
| Department of Treasury Customs | Interdiction | 122.0 | 122.2 | 124.0 | 121.3 | 103.6 | 99.2 | 183.7 | 133.7 | 265.3 | 208.6 | 239.7 | 213.4 |
| | Investigations | 11.4 | 11.4 | 13.9 | 13.6 | 30.4 | 30.2 | 39.6 | 40.2 | 44.7 | 41.7 | 52.2 | 46.5 |
| | Intelligence | 1.6 | 1.6 | 2.0 | 2.0 | 2.4 | 2.4 | 2.8 | 2.8 | 4.5 | 4.2 | 4.9 | 4.4 |
| | R & D | 1.8 | 1.8 | 1.6 | 1.6 | 1.5 | 1.5 | 1.2 | 1.2 | 1.5 | 1.4 | 1.3 | 1.2 |
| | Asset/Inter. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 7.7 | 7.5 |
| | Asset/SL Asst | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 6.0 | 4.9 | 5.8 | 5.8 |
| | | 136.8 | 137.0 | 141.5 | 138.5 | 137.9 | 133.3 | 227.3 | 177.9 | 302.0 | 260.8 | 311.6 | 278.8 |

AE1
File Name: ROLLUP
By Agency by Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| IRS | Investigations | 34.6 | 34.6 | 43.2 | 43.2 | 49.4 | 49.4 | 56.3 | 56.3 | 60.2 | 60.2 | 59.6 | 59.6 |
| | Prosecution | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.7 | 0.7 | 2.9 | 2.9 |
| | Reg. & Comply | 0.4 | 0.4 | 0.8 | 0.8 | 0.7 | 0.7 | 0.8 | 0.8 | 0.7 | 0.7 | 1.0 | 1.0 |
| | | 35.2 | 35.2 | 44.2 | 44.2 | 50.3 | 50.3 | 57.4 | 57.6 | 61.6 | 61.6 | 63.5 | 63.5 |
| BATF | Investigations | 0.0 | 0.0 | 1.5 | 0.5 | 4.6 | 2.9 | 8.3 | 8.1 | 9.5 | 9.3 | 7.5 | 7.3 |
| Payments to Puerto Rico | Interdiction | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Department of Treasury | | 172.0 | 172.2 | 187.2 | 183.2 | 192.8 | 186.5 | 293.0 | 243.4 | 373.1 | 331.7 | 382.6 | 349.6 |
| Department of Transportation | | | | | | | | | | | | | |
| Coast Guard | Interdiction | 227.5 | 227.4 | 328.9 | 328.9 | 359.9 | 359.9 | 508.2 | 508.2 | 506.6 | 506.7 | 397.8 | 441.0 |
| | R & D | 0.3 | 0.3 | 0.3 | 0.3 | 0.2 | 0.2 | 0.4 | 0.4 | 1.5 | 1.5 | 3.6 | 3.3 |
| | | 227.8 | 227.7 | 329.2 | 329.2 | 360.1 | 360.1 | 508.6 | 508.6 | 508.2 | 508.2 | 401.4 | 444.3 |
| FAA | Interdiction | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Intelligence | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| | Prevention | 0.4 | 0.4 | 0.2 | 0.2 | 0.4 | 0.4 | 0.5 | 0.5 | 0.4 | 0.4 | 0.5 | 0.5 |
| | | 0.4 | 0.4 | 0.2 | 0.2 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.6 | 0.6 |
| NHTSA | S&L Assistance | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Department of Transportation | | 228.2 | 228.1 | 329.5 | 329.5 | 360.5 | 360.5 | 509.1 | 509.1 | 508.6 | 508.6 | 402.0 | 444.9 |
| Department of State | | | | | | | | | | | | | |
| INM | International | 34.7 | 28.4 | 36.7 | 42.3 | 36.7 | 36.6 | 41.2 | 33.3 | 50.2 | 51.6 | 55.1 | 58.3 |
| AID (Direct) | International | 0.0 | 0.0 | 15.7 | 1.0 | 9.2 | 5.8 | 10.6 | 7.4 | 6.7 | 4.2 | 23.5 | 15.7 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 | 0.1 | 1.9 | 0.9 |
| | | 0.0 | 0.0 | 15.7 | 1.0 | 9.2 | 5.8 | 10.6 | 7.4 | 7.9 | 4.3 | 25.4 | 16.6 |
| USIA | International | 1.0 | 0.5 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Salaries & Expenses | International | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Department of State | | 35.7 | 28.8 | 53.4 | 44.3 | 46.9 | 43.4 | 52.8 | 41.7 | 59.1 | 56.9 | 81.5 | 75.9 |

AE1
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By Agency by Strategy

09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of Agriculture | | | | | | | | | | | | | |
| Agriculture Research Ser. | R & D | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 | 1.3 | 1.3 |
| U. S. Forest Service | Investigations | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.4 | 0.4 | 0.3 | 0.3 |
| | Intelligence | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | S & L Assist. | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 2.0 | 2.0 | 2.2 | 2.2 | 2.2 | 2.2 |
| | R & D | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.0 | 0.0 |
| | Reg. & Comply | 0.1 | 0.1 | 0.3 | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 0.2 | 0.2 | 0.6 | 0.6 |
| | | 0.5 | 0.5 | 0.7 | 0.7 | 0.8 | 0.8 | 2.6 | 2.6 | 3.0 | 3.0 | 3.1 | 3.1 |
| Subtotal, Department of Agriculture | | 1.9 | 1.9 | 2.1 | 2.1 | 2.2 | 2.2 | 4.0 | 4.0 | 4.4 | 4.4 | 4.4 | 4.4 |
| Department of Interior | | | | | | | | | | | | | |
| Bureau of Land Management | S & L Assist. | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.7 | 0.7 |
| | Investigations | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.4 |
| | | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 1.0 | 1.0 |
| U. S. Park Service | Investigations | 0.1 | 0.1 | 0.2 | 0.2 | 0.5 | 0.5 | 0.7 | 0.7 | 0.8 | 0.8 | 0.2 | 0.2 |
| Bureau of Indian Affairs | S & L Assist. | 1.0 | 1.0 | 1.1 | 1.1 | 1.1 | 1.1 | 1.2 | 1.2 | 1.2 | 1.2 | 2.8 | 2.8 |
| | Investigations | 0.7 | 0.7 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 1.9 | 0.8 | 1.7 | 1.7 |
| | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Treatment | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | 1.7 | 1.7 | 1.9 | 1.9 | 1.9 | 1.9 | 2.0 | 2.0 | 3.1 | 2.0 | 4.5 | 4.5 |
| Fish and Wildlife Service | S & L Assist. | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.4 | 0.4 | 0.3 | 0.3 |
| Subtotal, Department of Interior | | 1.9 | 1.9 | 2.2 | 2.2 | 2.8 | 2.8 | 3.1 | 3.1 | 4.5 | 3.4 | 6.0 | 6.0 |
| Department of Defense | Interdiction | 8.0 | 8.0 | 4.9 | 4.9 | 9.7 | 8.0 | 14.6 | 13.0 | 54.8 | 44.9 | 105.7 | 73.7 |
| | Prevention | 21.2 | 15.5 | 36.2 | 30.9 | 46.4 | 42.1 | 69.8 | 47.1 | 63.0 | 57.8 | 65.4 | 60.9 |
| | Treatment | 12.4 | 9.1 | 21.4 | 18.3 | 23.3 | 21.8 | 24.1 | 23.1 | 18.5 | 19.2 | 19.6 | 18.9 |
| | | 33.6 | 24.6 | 62.5 | 53.2 | 79.4 | 71.9 | 88.5 | 83.2 | 136.3 | 121.0 | 188.7 | 153.5 |

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09-Feb-89

FEDERAL DRUG LAW ENFORCEMENT AND ABUSE SUMMARY
(Budget Authority and Outlays in millions)

| | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays | BA | Outlays |
| Department of HHS | | | | | | | | | | | | | |
| Alcohol, Drug Abuse & Mental Health Admin. | Prevention | 95.0 | 92.7 | 79.8 | 80.9 | 86.2 | 85.2 | 97.3 | 97.1 | 108.7 | 108.2 | 121.9 | 120.2 |
| | Treatment | 144.0 | 140.6 | 81.2 | 83.3 | 96.8 | 96.5 | 96.1 | 95.9 | 101.9 | 102.5 | 97.5 | 97.2 |
| | | 239.0 | 233.3 | 161.1 | 164.2 | 183.1 | 181.7 | 193.4 | 193.0 | 210.6 | 210.7 | 219.4 | 217.4 |
| Food and Drug Admin. | Reg. & Comply | 1.4 | 1.4 | 0.8 | 0.8 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 1.6 | 1.6 |
| Indian Health Service | Treatment | 1.5 | 1.5 | 1.6 | 1.7 | 2.1 | 2.0 | 2.3 | 2.2 | 2.4 | 2.4 | 2.4 | 2.4 |
| Other HHS | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Department of HHS | | 241.9 | 236.2 | 163.5 | 166.7 | 185.9 | 184.4 | 196.4 | 195.9 | 213.7 | 213.8 | 223.4 | 221.4 |
| Department of Education | Prevention | 2.9 | 2.9 | 2.9 | 3.5 | 2.9 | 2.1 | 2.9 | 2.7 | 3.0 | 3.7 | 2.9 | 2.3 |
| Department of Labor | Prevention | 3.4 | 3.4 | 1.4 | 1.4 | 0.6 | 0.6 | 0.4 | 0.2 | 0.4 | 0.3 | 0.1 | 0.3 |
| Department of V. A. | Treatment | 52.0 | 51.8 | 55.8 | 55.6 | 60.5 | 60.3 | 63.3 | 61.1 | 66.6 | 64.3 | 68.4 | 68.1 |
| ACTION | Prevention | 2.5 | 2.5 | 6.8 | 6.8 | 6.9 | 6.9 | 6.8 | 6.8 | 6.9 | 6.9 | 6.9 | 6.9 |
| White House Conference | Prevention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Subtotal, Drug Law Enforcement | | 800.0 | 805.7 | 1,020.5 | 981.3 | 1,207.7 | 1,184.1 | 1,498.7 | 1,415.3 | 1,769.7 | 1,676.7 | 1,875.6 | 1,807.6 |
| Subtotal, Drug Abuse Prevention | | 125.2 | 117.3 | 127.2 | 123.6 | 143.3 | 137.3 | 157.7 | 154.4 | 183.7 | 177.6 | 201.3 | 194.8 |
| Subtotal, Drug Abuse Treatment | | 212.8 | 205.8 | 162.9 | 161.7 | 185.5 | 183.2 | 188.5 | 184.8 | 192.5 | 191.4 | 192.4 | 190.1 |
| TOTAL, FEDERAL DRUG SUMMARY | | 1,138.0 | 1,128.8 | 1,310.6 | 1,266.7 | 1,536.6 | 1,504.6 | 1,844.8 | 1,754.5 | 2,145.9 | 2,045.5 | 2,269.1 | 2,192.3 |

The CHAIRMAN. Very good, very well stated. I might have a few questions that I will submit to you, and they will be made a part of the record.

I want to thank you all. As I mentioned to the other witnesses, we will be very much involved in helping to shape the aspects of research, education, prevention, and rehabilitation in this committee. And we have every intention of filling that responsibility. And I think we had a very useful and important hearing today outlining many of those programs. We will be keeping in touch with you.

The subcommittee stands in recess.

[Whereupon, at 1:00 p.m., the subcommittee recessed, subject to the call of the Chair.]

# DRUG CRISIS: TREATMENT AND PREVENTION

WEDNESDAY, OCTOBER 25, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
*Washington, DC.*

The committee met, pursuant to notice, at 9:45 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Simon, Hatch, Coats, Durenberger, and Cochran.

## OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We'll come to order.

The subject matter of today's hearing is of enormous importance to our country and to millions of families across our Nation and people around the world who look to the United States for inspiration and for example in the areas of drug addiction research, prevention, and of treatment and rehabilitation.

As we see an increasing appreciation in the Congress and in the country of the importance of dealing with the demand-side aspect of this terrible national affliction, we will listen very closely and carefully this morning to those who have in so many instances spent a lifetime trying to ensure that our Nation is going to invest productively in the areas of research, prevention, and of rehabilitation and treatment of our fellow citizens.

So we look forward eagerly to the testimony of those who are with us here this morning.

I will include my entire statement as if read in the record.

[The prepared statement of Senator Kennedy follows:]

## PREPARED STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. I want to welcome everyone here today for our hearing on drug abuse treatment.

The problem of drug abuse is our society has become a national tragedy as we witness the crisis it is causing for families and communities across the country. We must stop the war of rhetoric and begin the real war—with challenging yet attainable goals and a realistic commitment of resources to halt the deterioration.

One of the most difficult challenges facing us is the effective use of our limited funds to help those who are already addicted to drugs. The criticisms of treatment programs abound, but the hard evidence—which will be presented today—is that drug treatment

for those who want to be cured of their addiction is both effective and economical.

A study by the Research Triangle Institute found that reduction in crime-related costs alone more than paid for the cost of treatment, whether in residential care, methadone maintenance or outpatient drug-free treatment.

A tour of a hospital wing dedicated to treating crack-addicted babies is enough to convince anyone that we must intensify our commitment to provide the help they need. A Florida study pinpoints the financial burden of drugs; it costs that State $700 million just to prepare "crack babies" for kindergarten.

The spread of AIDS through IV-drug use exacerbates a new tragedy. Alarming facts show that 50 percent of the IV-drug users in New York City are HIV-positive. The majority of these afflicted are told to wait 6 months to treat their drug addiction and their AIDS disease.

To people who claim that treatment is not cost-effective—I say they are wrong. We will pay now or we will pay later—not only in dollars but in lives lost. As Admiral Watkins used to say as chair of the Presidential Commission on AIDS, "we can invest $4,000 to treat a drug user's addiction, $14,000 to lock him up for a year, or $64,000 to treat him for AIDS." Support for drug treatment is a worthwhile investment in our future—and at a sum far less than the cost of inaction.

The greatest hypocrisy is for government to escalate its words in the war on drugs, without a corresponding escalation of resources.

How can treatment be effective if an addict who finally finds the courage to come forward to ask for help—is told to return in 6 months and turned back onto the streets?

How can treatment be effective if a drug addict with AIDS is not given immediate help to prevent the disease from spreading to other members of our society?

Even for those drug addicts fortunate enough to obtain treatment, how can it be effective if, upon completion of their therapy, they are not provided the necessary after care services for employment, housing, and counseling to prevent their return to the drug environment?

A vast expansion in the Nation's ability to provide treatment programs for IV-drug users was the No. 1 recommendation of the President's AIDS Commission.

And in the 1988 Drug Bill, Congress adopted a national policy goal: "To increase, to the greatest extent possible, the availability and quality of treatment services so that treatment on request may be provided to all individuals desiring to rid themselves of their substance abuse problems." Today, we remain thousands of miles and billions of dollars from reaching these goals.

For many years, the Federal Government has been waging the drug war by increasing the resources for law enforcement on the streets and interdiction at the borders. A comparatively small amount of money was spent in curbing the demand for drugs through prevention and treatment.

While interdiction and law enforcement must be ongoing components of our national anti-drug effort—our long-term strategy will only succeed through effective prevention and treatment programs.

Prevention is cost-effective in the anti-drug abuse effort. There is no better method of curing drug abuse than keeping it from starting. For the millions of Americans already addicted to drugs, prevention is not the answer—they need effective treatment and they need it immediately.

Research is essential too. As professional providers and researchers struggle to develop effective treatment programs for drugs such as heroin, cocaine and crack, they find themselves under increasing pressure with the onslaught of new types of drugs such as "ice" and "crack." They cannot be expected to succeed unless we give them the resources to expand their research.

Over the past month, Congress has finally responded with a responsible position to inject major resources into treatment and prevention. It is a position that I have long advocated.

Beginning in 1990, $700 million in new funding will be available for treatment alone. It is a major commitment of money and it must not be wasted.

These funds must be used for increased research, establishing effective treatment programs, eliminating the waiting lists, and providing "stopgap treatment" until everyone who needs it is cared for.

The treatment that we will hear today will assist us in the task of directing these new funds into programs that will be effective.

The drug problem did not appear overnight—and it will not disappear quickly. We must abandon the "short-term rhetorical fix" approach of recent years, and commit ourselves to the long-term struggle which alone can lead to a drug-free society.

Senator Hatch.

## Opening Statement of Senator Hatch

Senator Hatch. Mr. Chairman, thank you for holding these hearings, and I would like my statement included in the record as well.

I would just say that we have come a long way. In a record 22 days following the submission of the President's plan, the Senate affirmed our commitment to fight drugs at every front. And I might say we have increased law enforcement personnel to stop the supply of drugs, as well as treatment and education programs to end the demand for drugs in America.

So I was pleased to work with you, Mr. Chairman, in putting accountability into our programs. In both S. 1711, the Transportation Appropriations bill, and S. 1736, the Omnibus Drug Abuse Bill, we are requiring States to implement plans to ensure that the schools are drug-free, and we are requiring States to be accountable for the types of drug treatment programs they are funding.

Now, we have to have confidence that the moneys that are used will be well-spent and that the people seeking treatment are offered treatment that is effective.

I understand that today we do not have the necessary medications to block the craving for cocaine and crack, so I am pleased that these hearings today will cover new research findings about new and emerging drug treatment therapies.

So I want to thank you, Mr. Chairman, and others on this committee for the bipartisan manner and way in which we have

worked together to expand services to pregnant and postpartum women and to expand child abuse treatment and prevention services to children of drug addicts and to expand our ability to train health care professionals who will treat drug addicts.

I could go on and on, but the fact is that I am pleased that Dr. Charles Schuster, director of the National Institute of Drug Abuse, is with us today. Dr. Schuster, of course, is highly regarded for his knowledge and experience in drug treatment, and I am personally anxious to learn about research findings on the chemical, psychological and physiological process of drug use and drug addiction.

So Dr. Schuster, I look forward to your testimony and that of other witnesses appearing here today.

The CHAIRMAN. Thank you very much, Senator Hatch.

[The prepared statement of Senator Hatch follows:]

PREPARED STATEMENT OF SENATOR HATCH

Senator HATCH. Mr. Chairman, today we are again meeting to discuss the problems of drug abuse in America. And, I am pleased that today's hearing lends a special focus on drug abuse treatment. The Senate recently passed landmark legislation to fully fund President Bush's strategy to combat drug abuse, and we added 11 percent to the appropriation. In a record 22 days following the submission of the President's plan, the Senate affirmed our commitment to fight drugs at every front. We have increased law enforcement personnel to stop the supply of drugs as well as treatment and education programs to end the demand for drugs in America.

In addition, I was pleased to work with you, Mr. Chairman, in putting accountability into our programs. In both S. 1711, the Transportation Appropriations bill, and in S. 1735, the Omnibus Drug Abuse bill, we are requiring States to implement plans to ensure that the schools are drug-free. And, we are requiring States to be accountable for the types of drug treatment programs they are funding. We should have confidence that the money will be well-spent and that people seeking treatment are offered treatment that is effective. I understand that today we do not have the necessary medications to block the craving for cocaine and crack. I am pleased that these hearings will cover new research findings about new and emerging drug treatment therapies.

I thank you, Mr. Chairman, and others on this committee, for the bipartisan manner in which we developed other language to expand services to pregnant and post-partum women, to expand child abuse treatment and prevention services to children of drug addicts, and to expand our ability to train health care professionals who will treat drug addicts.

Unfortunately, that hard work on both S. 1711 and S. 1735 is languishing. The increased funding in the Transportation Appropriation bill faces great uncertainty as the House of Representatives plays "politics" with the war on drugs. Mr. Chairman, you and I, as well as others on this committee and in the Senate, believe that this war will not be won with a good political speech or good political posturing. It will be won when we have effective programs that treat substance abusers. It will be won when we have effective programs that educate parents and their children to stay away from

drugs. It will be won when we have jailed those who would push illegal drugs. That will be a great day for all America. So, I hope that we get some movement in the House on this Senate-passed legislation.

I am pleased that Dr. Charles Schuster, the director of the National Institute of Drug Abuse, is with us today. Dr. Schuster is highly regarded for his knowledge and experience in drug treatment. I am anxious to learn about research findings on the chemical psychological and physiological processes of drug use and drug addiction. I look forward to your testimony, Dr. Schuster, and that of other witnesses appearing here today.

I look forward to hearing from the witnesses. I think we have tended to focus on the more dramatic side of the drug problem. It sounds like you are really doing something if you are putting someone in prison. I think we have to focus a great deal more attention on treatment and education. It is not nearly as dramatic. My instinct is in the long run it will be a much wiser investment of funds—not that we do not want strong law enforcement; obviously, we do—but we are here for your guidance, and I appreciate your holding these hearings.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Our first witness will be Dr. Charles Schuster, director of the National Institute on Drug Abuse. Dr. Schuster is one of the preeminent treatment and research experts in the country. His testimony will deal with national treatment and treatment research needs.

We look forward to hearing from you.

## STATEMENT OF DR. CHARLES R. SCHUSTER, PH.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, BETHESDA, MD

Dr. SCHUSTER. Thank you very much, Senator Kennedy, Senator Simon, Senator Hatch.

I am very pleased to be here this morning. I apologize if I am a little less articulate than usual, but I just flew in from California in order to be here. I was meeting with a pharmaceutical firm yesterday, and I am pleased to say it is one of the first that I have come across that has an active program on its own for the development of medications for the treatment of addictive disorders.

So I have prepared a very lengthy statement which I would like to have submitted for the record.

The CHAIRMAN. It will be so included as if read.

Dr. SCHUSTER. Thank you.

In the statement, I have gone over the historical background on the epidemiology of drug abuse in the United States with particular reference for treatment need; an overview of the efficacy of the treatment system; and an outline of our plans for the developing new medications for the treatment of drug abuse.

Before I try to summarize very briefly those three areas, let me begin with a couple of, I think, summary statements.

I think if you carefully review all of the research on treatment efficacy, we could say that treatment has been the most underutilized cost-effective intervention strategy in our effort to control drugs.

Why is treatment important? Well, it is obviously important from the individual's viewpoint and from his family and from the community that he interacts with because we know that treatment will decrease illicit drug use, decrease crime, decrease the possibility of the spread of HIV and other infections amongst people who are sharing needles, and also increase pro-social behaviors such as appropriate work or education or homemaking.

But I think it is also important to recognize that treatment and getting active drug users into treatment is essential because they actively subvert all of our prevention efforts. At least during the early phases of an individual's addictive career, there is a lot of glamour associated with it, and these people serve as role models for younger people.

Second, the presence of addicts in a community guarantee that drugs are going to be available for those of our youth who wish to experiment with them. So we must be able to bring these people into treatment if our prevention programs are going to be maximally effective.

That is one of the reasons why I am pleased to participate in this program this morning because I think it focuses attention on the need for treatment and on where we are in relationship to this need.

First of all, let's very briefly say something about the epidemiology of drug use in this country. It is a confusing picture. If you look at mainstream America as indicated by our household survey and our high school senior survey, there is simply no question that many, many people have stopped using illicit drugs, and fortunately our youth, those 12 to 17 years of age, are not initiating drug use to the same extent that they did back in 1979.

In 1979, 11 percent of high school seniors smoked marijuana on a daily basis. That is down to 2½ percent or less today.

On the other hand, those who continue to use drugs are using them in more intensive fashions and are using drugs which because of their nature, such as crack, are inherently more addictive and more dangerous. So we have two diverse things going on here—an increase in the intensity of drug use amongst those who are using drugs, but an overall decrease. I think this confuses the public.

The CHAIRMAN. Excuse me—we'll try to move the hearing along without too many interruptions, but I welcome interventions as our witness proceeds. What do you account for that reduction?

Dr. SCHUSTER. Well, I think that to a great extent it is attributable to a lot of our prevention efforts—our media prevention efforts, our high school curriculum on drug abuse—because one of the things that we have seen, for example, in the high school senior survey, is that attitudes have changed remarkably toward the acceptability and second toward how children perceive the dangerousness of even casual drug use. It has gone up that they are saying, "Hey, this is dumb, and it is dangerous, and I don't want to be doing it, I don't like my friends doing it." That attitudinal change usually precedes by a year the behavioral change of actually the fall in the incidence and prevalence of drug use.

So I think we are being effective in many areas with prevention programs, and we actually have data about that.

On the other hand, we have to say that there are many sections of our country where these prevention programs are either not being utilized, or they may not be culturally relevant, or they may simply be ineffective in certain portions of our population.

Now, I think that the best illustration of the fact that there is an increase in intensity of drug use amongst those who are continuing to use drugs is the evidence on cocaine where we have found over the past 5 years from 1984 through 1988 that there has been virtually a fivefold increase in the number of people who have ended up in emergency rooms because of the use of cocaine. It has gone from about 8,000 mentions in 1984 to over 46,000 in 1988.

Similarly, the number of medical examiner reports—deaths associated with cocaine use—has shown about a fourfold increase over the same period of time.

And finally, in the last 4 years, the number of people who are coming into treatment programs saying that they need help because of their cocaine addiction has tripled from about 40,000 to over 130,000.

So all of these indications would say that we have a major public health problem despite the fact that there are a decreasing number of people who are involved in illicit drug use.

Well, although I started off by saying that treatment is a cost-effective strategy in the war on drugs, I want to emphasize the fact that it is still not nearly as good as it could be. We desperately need new research, particularly as was alluded to previously by Senator Hatch, for those who are addicted to cocaine.

I am pleased to say that we have some interesting leads here. First of all, we now understand to a much greater extent than we ever did the neurobiology of cocaine's actions on the brain that are responsible for its addictive properties. Our research in this area has literally leapt ahead in the past 5 years.

Second, we have some very interesting new medications that have shown promise for decreasing the craving of people who are trying, honestly trying, to stop using cocaine; but the incredible craving which they episodically suffer, leading to relapse to drug use, has met a major stumbling block. We now have medications that appear that they are able to block this craving and assist the individual in terms of remaining drug-free, and information about that is included in my testimony and I'd be happy to answer any questions about it.

Finally, I'd like to emphasize the fact that medications are only one part of an overall treatment strategy. Many of the people that we deal with today who are using drugs intensively are individuals who have inadequate education, inadequate job training, and oftentimes are suffering from other types of psychiatric disorders. As many as 80 percent of people who enter drug treatment programs have at least in their lifetime a diagnosable psychiatric disorder other than substance abuse. That complicates the picture. And I have to say to you that many treatment programs in the United States do not have the professional expertise to deal with the concomitant psychiatric disorders at the same time as they are dealing with the drug abuse problems.

Senator HATCH. What percentage was that again—80 percent?

Dr. SCHUSTER. Eighty percent have a lifetime prevalence; of those coming in for treatment. For those coming in for treatment, it has been estimated that as many as 80 percent have a lifetime prevalence——

Senator HATCH. An underlying problem, emotional problem.

Dr. SCHUSTER. Of another disorder, affective disorder, schizophrenia.

Senator HATCH. What about those who don't come in? Is there any way of measuring that?

Dr. SCHUSTER. I'm sorry—who are not in treatment?

Senator HATCH. Those who do not come in, who are not in treatment. Would you estimate it is almost as high or as high?

Dr. SCHUSTER. I'm sure that it is as high. I think the important thing here is that all of our research has shown that in order for us to be effective in treating the substance abuse disorder, we have to be able to treat the depression or the schizophrenia and vice versa.

We know, for example, that rehospitalization among schizophrenics, probably the No. 1 cause of their rehospitalization is an episode of alcohol or drug abuse, and they decompensate and have to be rehospitalized because of this.

So these problems are interacting, and the overlap between the populations is, as I say, very, very high.

Well, in summary, I would like to again say that I think there are many other aspects other than simply medications that have to be included in comprehensive drug abuse treatment programs, and I think it is fair to say that many of our treatment programs in the United States today do not have these other services.

Some people call them "ancillary" services; I don't. I think they are essential services. I am talking now about the job skill training, about the literacy training, about the necessity for counseling, for individuals to be able to be reunited with their families, as well as the professional help that they need to overcome these coexisting psychiatric disorders.

It is a fact that over the past decade the amount of money that is spent per treatment slot has gone down about 38 percent. And I will say to you that I am concerned about Congress' call for accountability for treatment programs at a time when those treatment programs have been weakened because of the fact that inflation has taken away a number of the services which are essential for these treatment programs to be up to the par that they should and could be.

Therefore, I would say to you that I think it is important to not only think about expanding treatment capacity with increased dollars from Congress, but as well increasing the amount that is spent per treatment slot, so that those treatment slots can be used most effectively and have the other services associated with them so that we are talking now about real habilitation and rehabilitation for these people who need it.

I'll stop now and will be happy to answer questions.

[The prepared statement of Dr. Schuster follows:]

## PREPARED STATEMENT OF CHARLES R. SCHUSTER, PH.D.

Mr. Chairman and Members of the Committee, I am Dr. Charles R. Schuster, Director of the National Institute on Drug Abuse. I am pleased to appear at this hearing to discuss treatment of drug abuse in the United States.

### NATURE AND EXTENT OF DRUG ABUSE IN THE UNITED STATES

During the past two decades, drug abuse has become widespread in the United States. Estimates developed from surveys conducted in the 1970's suggest that less than 5 percent of the population had experience with illicit drug use (including the use of marijuana, hashish, cocaine, inhalants, hallucinogens, heroin, and nonmedical use of psychotherapeutic drugs) in the early 1960's (NIDA 1979). However, by the early 1970's, that estimate had increased to over 10 percent, primarily due to use by young people (NIDA to be published). Over half of young adults (age 18-25) and over one-fifth of youth (age 12-17) in 1974 had tried illicit drugs at some time in their lives. As this cohort of young people grew older and as younger cohorts continued to experiment with illicit drugs, the percent of the population having used illicit drugs in their lifetime increased rapidly during the 1970's and 1980's, until by 1988 an estimated 36.6 percent (72.5 million) of Americans age 12 and older had used illicit drugs. Experience with illicit drugs is no longer restricted to youth and young adults, as nearly a quarter (23 percent) of adults age 35 and older had tried illicit drugs by 1988.

While experimentation with illicit drugs has been widespread and represents an illegal behavior as well as an increase in risk for experiencing various adverse consequences associated with drug abuse, it is also true that most of the 72.5 million Americans who have tried illicit drugs no longer use them. In 1988, 28.0 million people, or 14.1 percent of the population age 12 and older, had used illicit drugs during the past year. Furthermore, 14.5 million people, or 7.3 percent of the population age 12 and older, were current (past month) illicit drug users. Thus, past year users represent less than half of the lifetime users, and current users represent only one-fifth of lifetime users. It is these past year and past month users who are of most concern because they are at the highest risk of suffering the consequences of drug abuse.

An index developed by NIDA shows that about 7.6 million people, or more than one-quarter of the past year users age 12 and older, were classified as "heavy" users in 1988 (i.e., they used 50 or more times in the past year). About half (14.3 million) of the past year users were classified as "experimental" or "occasional" users (less than 12 times in the year), and the remaining 6.1 million people were classified as "regular" users (12 to 49 times).

Although illicit drug use continues to be more prevalent among young people today than it was in the 1960's, in recent years there have been encouraging trends in drug abuse prevalence. The aging of the cohorts with high rates of use has resulted in increases in overall (total population) lifetime prevalence rates due to the cumulative nature of these estimates, but lifetime prevalence among young people and current prevalence among all age groups have declined since 1979. Today's youth are less likely to use illicit drugs than were the youth of 1979. Between 1979, which appears to have been the peak

year for drug abuse prevalence, and 1988, the lifetime prevalences of use of marijuana, hallucinogens, cocaine, cigarettes, and alcohol have all decreased significantly among youth age 12-17 and also among young adults age 18-25. Among high school seniors, similar decreases have been observed in lifetime as well as current use of drugs. In the total household population, a decreasing trend in current (past month) use of illicit drugs has occurred since 1979, with particularly large decreases between 1985 and 1988. Current prevalence of any illicit drug use decreased from 23.0 million (12.1 percent of the population aged 12 and over) in 1985 to 14.5 million (7.3 percent) in 1988.

There was a significant decline between 1985 and 1988 in the percentage of high school seniors who reported using cocaine during the past month, a trend that is consistent with the downward trend seen in the household population, where prevalence declined from 5.8 million users in 1985 to 2.9 million users in 1988. One factor that seems to have played a role in the reduction in drug use is an increasing awareness on the part of high school students that use of illicit drugs is dangerous. This increased awareness is evident in the household population as well. For example, 31 percent of youth age 12-17 in 1985 reported that there was "great risk" in trying cocaine, while in 1988 that estimate had reached 53 percent. Similar increases in perceived risk occurred for other age groups and for other drugs.

Because polydrug use is common among drug users, focusing on a single drug of abuse cannot provide a complete picture of the nature and extent of drug abuse. However, studying the problem in terms of prevalence of use of each of the major drugs does provide a way of looking more closely at patterns of use and differences among population groups.

## Marijuana Use

Marijuana remains the most commonly used illicit drug in the United States. Almost 66 million Americans (33.2 percent) have tried marijuana at least once in their lives. Four million youth, 17 million young adults, and over 45 million adults age 26 and older have tried marijuana. Marijuana has been called a "gateway drug" because its use is associated with the use of other drugs. For example, lifetime cocaine use is rare (less than half of 1 percent) among people who have never used marijuana and the likelihood of having used cocaine increases as the frequency of use of marijuana increases. Among people who have used marijuana 200 or more times in their life, 77.4 percent have tried cocaine.

Current use of marijuana was estimated at 5.9 percent (11.6 million) of the population age 12 and older in 1988. Current use was higher for males (7.9 percent), for young adults age 18-25 (15.5 percent), for the unemployed (14.8 percent), and for those living in large metropolitan areas (6.9 percent), which are defined as metropolitan areas having at least 1 million population in 1980. Of the 21.1 million people who used marijuana in the past year, almost one-third, or 6.6 million, used the drug once a week or more often.

## Cocaine

The number of lifetime users of cocaine was 21.2 million in 1988, representing 10.7 percent of the population 12 and older. The overall rate of current use was 1.5 percent, but males (2.0 percent), those aged 18-25 (4.5 percent), the

unemployed (4.6 percent), and minorities (2.0 percent for blacks and 2.6 percent for Hispanics) had higher rates of use. Among the 8.2 million past year cocaine users in 1988, 10.5 percent used the drug once a week or more, while only 5.3 percent of the users in 1985 were weekly users. Thus, despite the decrease in the number of users that occurred between 1985 and 1988 (from 12.2 million past year users in 1985) there was no decrease and may in fact have been an increase in the number of heavy users.

While lifetime prevalence of cocaine use remained stable for whites and blacks between 1985 and 1988, a significant increase occurred among Hispanics, from 7.3 percent to 11.0 percent.

Approximately 1.3 percent of the population age 12 and over have used crack at some time in their life, and one-half of 1 percent used in the past year. This translates to about one million past year crack users in 1988.

Heroin Use

Household surveys do not adequately measure the prevalence of heroin use and are believed to result in underestimation. Nevertheless, 1988 Household Survey data show that 1.9 million Americans (1.0 percent) have tried heroin, and 88 percent of these lifetime users were age 26 or older. Rates of lifetime use were highest for males (1.3 percent) and blacks (2.3 percent). Under a NIDA contract in progress, an estimate of the number of current heroin addicts is being developed using mathematical modeling. Previous modeling such as this resulted in estimates of about 500,000 heroin addicts in 1982.

Intravenous Drug Use

While accurate data on the number of intravenous (IV) drug users in the U.S. do not exist, researchers have speculated that the size of this population is between 1 million and 1.5 million people. An estimate compiled from "best guess" estimates from individual State Alcohol and Drug Abuse Agencies was 1.3 million, with New York, California, and Pennsylvania reporting the largest numbers. Data from NIDA's 1985 client treatment data system (NIDA 1987) as well as more recent DAWN data indicate that most IV drug use involves heroin, cocaine, or amphetamines. Estimates from the 1988 Household Survey, which are conservative, indicate that 1.3 percent of the population age 12 and older, or 2.5 million people, have used one of these drugs intravenously at some time in their lives. Seventy-three percent of these IV users were male, and blacks had higher rates of use (2.0 percent) than whites (1.2 percent) or Hispanics (1.3 percent). Past year IV use occurred mainly among 18-34 year-olds.

Other Illicit Drug Use

Hallucinogens, which first gained prominence during the 1960's, include such drugs as LSD, PCP, mescaline, peyote, and MDMA ("Ecstasy"). Lifetime prevalence of these drugs is highest among 26-34 year-olds (17.7 percent) and current prevalence is highest among 18-25 year-olds (1.9 percent).

Nine percent of youth have experimented with inhalants, but current use is rare: only 2 percent of youth and young adults, and less than one-half of 1 percent of older adults are current inhalant users.

Current nonmedical use of psychotherapeutic drugs (sedatives, tranquilizers, stimulants, and analgesics) decreased from 3.2 percent in 1985 to less than 2 percent in 1988. Current use was slightly higher for females (2.0 percent) than males (1.4 percent), and was highest among 18-25 year-olds (3.8 percent). Stimulants, which include methamphetamine, were the most commonly used category of psychotherapeutic drugs among current users.

## CONSEQUENCES OF DRUG ABUSE

Despite the encouraging downward trends in prevalence during the 1980's, adverse health consequences related to substance abuse are increasing. In hospitals consistently reporting to the Drug Abuse Warning Network (DAWN), the number of people admitted to emergency rooms following cocaine use increased from 8,831 in 1984 to 46,020 in 1988. Much of this increase is accounted for by increases in cases involving the smoking of cocaine, primarily crack cocaine. Cocaine smoking cases increased from 549 in 1984 to 15,306 in 1988. Further, the number of people who died following cocaine use, as reported by DAWN, more than tripled during the same time period. Some of the factors which contribute to increases in health consequences during a period of declining prevalence, among people who continue to use, are: increases in frequency of use, increases in dosages, increases in drug purity, changes in route of administration to more dangerous routes (e.g., smoking and injecting cocaine), the use of drugs in combination, and complications associated with long-term use and aging of the user.

Data on the characteristics of people suffering the negative consequences of drug abuse help to identify the segments of the population most severely affected by drug abuse. These data can also help identify the patterns of use and types of drugs used that are most likely to result in adverse effects.

### Drug Abuse Related Deaths

The majority of drug-related deaths reported to DAWN as having occurred in 1988 involved either cocaine (49 percent ) or heroin (37 percent). Many of these deaths involved heroin and cocaine in combination, commonly called "speedballing." Alcohol was also a factor in 38 percent of deaths reported to DAWN, although alcohol deaths are not included in DAWN if other drugs are not involved. Males accounted for 80 percent of the cocaine-related deaths, 83 percent of the heroin-related deaths, and 73 percent of all deaths reported to DAWN. Blacks accounted for 41 percent of cocaine-related deaths and 32 percent of heroin-related deaths, even though blacks comprise only 16 percent of the U.S. population in large metropolitan areas (estimated from the 1988 National Household Survey on Drug Abuse data file), which the DAWN data generally reflect. Half of the heroin deaths and almost half of the cocaine deaths occurred among 30-39 year-olds, but cocaine deaths were more likely to involve people under age 30 than were heroin deaths.

### Emergency Room Episodes

Cocaine is the single drug most frequently involved in emergency related reports to DAWN accounting for more than one-third of all episodes in 1988 . Males accounted for 56 percent of all drug episodes, but 67 percent of cocaine mentions, 70 percent of heroin mentions, 75 percent of PCP mentions, and 72 percent of marijuana/hashish mentions (most of which involved other drugs).

Patients aged 20-29 constituted 38 percent of the DAWN emergency room episodes while those aged 30-39 years accounted for 32 percent. Nine percent of the emergency room episodes were for persons 6-17 years of age.
Heroin accounted for 16 percent of black emergency room episodes, 18 percent of Hispanic episodes, and 10 percent of white episodes. Cocaine was reported

in 56 percent of black episodes, 32 percent of Hispanic episodes, and 25 percent of white episodes. PCP was involved in 8 percent of black episodes, 6 percent of Hispanic episodes, and 3 percent of white episodes. Methamphetamine, on the other hand, was involved in 4 percent of white episodes, compared with less than 1 percent of black episodes, and 1 percent of Hispanic episodes.

### Drug Abusers in Treatment

Drug abuse treatment units responding to the National Drug and Alcoholism Treatment Unit Survey (NDATUS) reported that 263,510 drug abuse clients were in treatment on October 30, 1987. New York State had the largest number of clients, with 69,636, and California was second, with 40,522. These two States accounted for 42 percent of the Nation's clients. An estimated 67 percent of drug abuse clients were male, and the majority (56 percent) of clients were between the ages of 25 and 44. Youth under age 18 accounted for 15 percent of clients. Blacks and Hispanics comprised a larger proportion of the treatment population than is seen in the general population or even in the drug-using population identified by the National Household Survey. Twenty-five percent of clients were black and 16 percent were Hispanic. Application of U.S. population estimates to NDATUS client counts resulted in rates per hundred thousand population of 203 for blacks, 200 for Hispanics, and 68 for whites. An estimated 42 percent of drug abuse clients were intravenous drug users. Data from the State Alcohol and Drug Abuse Profile (SADAP) show that the primary drugs of abuse among treatment clients are heroin, cocaine, and marijuana. Estimates of admissions to treatment for cocaine abuse more than tripled from 1985 to 1988 (from 39,696 to 134,734) in State-supported treatment programs.

### Drugs and Crime

The impact that drug use has upon the criminal activities of individuals has been a topic of much concern in our society. In recent years, policymakers, health care providers, and law enforcement officials have declared that drug use and its related criminal activities is one of the most serious social problems facing our Nation. The National Drug Control Strategy sets forth concerns and and goals in this area that we need to address.

The magnitude of this problem has been explored in detail by research projects funded by the National Institute on Drug Abuse and other institutions. This research has yielded a number of significant results. It has been shown that drug-related crime cost American society approximately $20 billion dollars in 1983. The criminal activities of each daily heroin user cost society approximately $55,000 per year. The typical narcotic addict commits an average of 178 criminal offenses per year. If this result is generalized to an estimated 450,000 active heroin addicts living in the United States, it can be concluded that narcotic addicts commit over 80 million crimes every year. Approximately 38 percent of these crimes are drug related, and 22 percent include other "victimless crimes" such as prostitution, procuring, gambling, and alcohol violations. The remaining 40 percent include robbery and assaults, vehicle theft, shoplifting, selling stolen goods, forgery, counterfeiting, burglary and pickpocketing. Results from interviews conducted on serious juvenile delinquents in Miami, Florida, indicated that youth involved in the use and sale of crack cocaine committed an average of 880

criminal offenses per year. Sixty-one percent of their crimes were related to drug dealing-using offenses, 23 percent to petty property offenses, 4 percent to major felonies, and 11 percent to vice offenses and prostitution.

Results from urinalysis tests on male and female arrestees in 14 major urban areas show that from September to December 1988, approximately 75 percent of jail arrestees tested positive for drug use.

Violence has been shown to be related to illicit drug use resulting from involvement in the drug distribution network, and from interpersonal violence by female drug users against their children.

In summary, results from research funded by NIDA and other institutions provide evidence that drug use is a costly social problem which has been linked to child abuse, violent crimes, and other serious criminal offenses. Data indicate that drug addicts are responsible for a significant percentage of crimes, demonstrating the need for development of comprehensive law enforcement and treatment programs to address this problem.

## Drug Use During Pregnancy and Consequences

Data from the 1988 National Household Survey on Drug Abuse indicate that there are over 5 million women in the child-bearing age group (age 15-44) who are current users of an illicit drug, including about 1 million cocaine users and 4 million marijuana users.

In the case of pregnant women abusing drugs, however, there are no data available from any national surveys or studies. Only recently, a NIDA grantee, reported results of a pilot study of 36 mainly urban hospitals in the U.S., representing an annual delivery rate of about 155,000. The use of illicit drugs during pregnancy was between 0.4 and 27 percent, and that of cocaine alone was between 0.2 percent and 17 percent, depending upon the hospital. He estimated that as many as 375,000 infants may be affected from in-utero exposure to drugs each year in the U.S. However, the extent of use of these drugs during pregnancy was not known.

Drug abuse during pregnancy has been found to be associated with a number of obstetric and neonatal adverse consequences such as preterm delivery, abruptio placentae, low birth weight, infants born of small gestation age, and Sudden Infant Death Syndrome, in women who used/abused cocaine during pregnancy. In addition, isolated cases of seizures, cerebral infarction, urogenital birth defects in infants born to cocaine-abusing women have been reported.

## Drug Use by Employed Persons

Drug use is most prevalent in adults aged 18 through 34 years. This age group is also a major segment of our workforce. Although drug use prevalence is higher among unemployed than among employed persons, nearly 17 percent of full-time employed 18-25 year-olds had used marijuana in the past month. For the age group of 26 to 34 years, 11 percent of the full-time employed had used marijuana in the past month. Drug use prevalence decreased with increasing age among full-time employed people.

Drugs, including alcohol, in the workplace can interfere with an employee's productivity and safe performance of job responsibilities. The use of drugs can also reduce an employee's dependability by increasing the number of days lost from work. Drug use by the members of the American workforce carries with it all the risks and problems associated with drug dependence. Studies on the human and economic cost of drug abuse indicate that the direct and indirect costs of drug abuse to business are substantial. These include decreased productivity, absenteeism, accidents at the workplace, health care, loss of trained personnel, theft, and the costs associated with prevention treatment, and deterrence programs.

## TREATMENT AS A DRUG ABUSE CONTROL STRATEGY

The vast majority of the persons who try drugs briefly experiment with them and, recognizing that drugs play no positive role in their lives, refrain from further use. Some continue to use until it comes to the attention of employers or family, or until they are motivated to stop because of the physical and psychological harm that illicit drug use causes. With a little help, these individuals can become drug free. A proportion of illicit drug users become severely dependent, cease to function in legitimate social roles and usually engage in criminal behavior as part of their drug-using lifestyle. It is this group that accounts for the bulk of the social and economic problems commonly associated with drug abuse, i.e., the $47 billion per year for health care, reduced productivity, costs of law enforcement, and theft and destruction of property. This is the group that ensures that the illicit drug distribution system always has a market.

Acquired Immunodeficiency Syndrome (AIDS) has added a new dimension to the nation's drug abuse problem. Needle sharing among intravenous drug abusers can result in rapid transmission of the AIDS virus, and intravenous drug abusers constitute the second largest risk group comprising 27 percent of all adults with AIDS. Of the more than one million needle using drug abusers in major metropolitan areas, increasing numbers are testing positive for the AIDS virus. In New York and northern New Jersey, approximately 60 percent of recent entries into treatment programs for heroin addiction are infected with the AIDS virus. For the present, the prevalence of infection is lower in most other parts of the country. Preventing further spread of AIDS among IV drug abusers and from IV drug abusers to their sexual partners and on into the general population must be a priority. The fact that many intravenous drug abusers have non-drug using sexual partners and that many prostitutes are intravenous drug abusers gives a sense of inevitability about the spread of the virus to the general population. The issue is no longer whether it will occur, but how to reduce the rate of spread so as to minimize the tragedy of lives lost and the immense National economic costs.

### Matching Treatment to the Drug Abuser

Studies over the last 15 years consistently show that drug abuse treatment has a positive impact on both drug use and antisocial behavior. What has also emerged from these studies is the realization that, within the overall gains brought about by treatment, some who sought treatment improved with relatively little help; others did well, but only with long-term treatment or specific pharmacological interventions; still others showed little or no improvement even when provided with a variety of treatment approaches.

Those who improved with brief treatment tended to be the least impaired psychologically, had held legitimate jobs sometime in their past, and had been able to establish stable relationships with others. Studies have also shown that those who are severely psychiatrically disturbed tend to do poorly no matter which of the currently available programs they enter. The prevalence of psychiatric disorders in severely dependent drug abusers is quite high, with about 80 percent of patients entering substance abuse treatment programs having had a diagnosable mental health problem at some time in their lives. A drug abuser with a psychiatric disorder can have a much-improved treatment

outcome if the psychiatric condition is properly diagnosed and treated. However, most drug abuse treatment programs (especially those that are publicly financed) do not have the professional personnel to provide these services.

Additional factors that reduce the likelihood of successful response to treatment are an absence of educational and vocational skills, a history of multiple criminal convictions, and the absence of stable interpersonal relationships. These findings imply a need to focus additional research on new treatments and on those patients who have multiple problems and poor prognoses.

For purposes of projecting needs for different types of treatment and associated costs, it is helpful to attempt to subdivide the population of illicit drug users in need of some form of intervention into several categories. The categories are based on the liklihood of eliciting a positive change in drug related behavior and the resources needed to bring about that change. These categories are summarized in Table 1.

The treatment system that exists in the United States for problems of drug abuse is not unlike what exists for most forms of human distress or illness: a great deal of self-help, self-diagnosis, and help and advice from friends and family, with only the more severe situations calling for formal treatment. Even in more serious situations, only the most severe and most complicated cases require the more costly specialized treatments.

### How Many Would Enter Treatment?

Many drug abusers are disposed to seek treatment. This fact was demonstrated in a recent survey of cities. Three out of four of the cities reported long waiting lists of drug abusers seeking treatment in publicly funded programs. In some places the waiting time could be as long as six months. The drug abuse treatment network has been confronted with waiting lists in the past. Short bursts of funding designed to eliminate waiting lists do not always result in the lists shrinking. Often, as the news of treatment availability reaches the street, drug abusers flood the programs.

The drug abusing life style can be extremely exciting at first, but as Hanson, Beschner, Walters, and Bovelle stated in their study of the personal and social world of heroin addicts:

> The lifestyle can also become self-defeating. "Taking care of business" requires an enormous investment of emotional energy, time, and money. To succeed, addicts must engage in an absorbing and rigorous daily routine of hustling and copping. Each day is structured by the needs to make money, to maintain contacts, and to purchase drugs, and beyond that, to find time to get high.

Of the 124 black men, 60 percent said that they would consider entering treatment under some circumstances. None of these individuals were in treatment at the time, nor had they ever been in treatment. The study was done before AIDS became a serious public health issue.

Table 1
Categories of Drug Abusers and Intervention Resources Required

| Severity | Intervention |
|---|---|
| Mildly Impaired | Responds to personal drug crisis; threat of urine testing; or, admonitions of employer, or family. Treatment is usually not required. |
| Moderately Disabled | Many respond to self-help groups (e.g., A.A., N.A.) or minimal counseling or supervision. Most require a planned program of outpatient or residential treatment consisting of drug counseling, detoxification, and/or pharmacological support (methadone, naltrexone for opiate abuse or anti-depressants for cocaine). |
| Severely Disabled | Severely socially disadvantaged or diagnosable psychopathology requiring special services (e.g., psychotherapy, vocational or other rehabilitative services), but when such services are provided these individuals show substantial improvement. |
| Extremely Disabled | Social impairment and/or psychopathology exceeds the level that can be successfully addressed by current methods may require chronic care, or compulsory confinement. |

As the AIDS epidemic worsens, it is likely that a growing number of intravenous drug abusers will voluntarily seek treatment for their drug problems as a way of reducing the chance of getting AIDS. In a more recent study in New Jersey, free vouchers that could be redeemed for detoxification services were distributed to intravenous drug abusers on the street. Of the first 1,000 distributed, 80 percent were redeemed at treatment programs. Of those redeeming their vouchers, 40 percent had not previously been in treatment.

For those who resist seeking help for their problem, the police and courts are always there as a prod--compulsion is significant as a motivator to enter treatment. Based on a 1985 NIDA survey of admissions to treatment programs in 15 States, it is estimated that about 27 percent of those seeking help in publically supported treatment programs do so under some form of legal pressure. There is a large population of drug abusers that pass through the criminal justice and corrections system every year. It is likely that, if treatment capacity is increased, treatment programs will be seen as a solution to prison overcrowding. How significant a referral source can this be? In 1983, the U.S. Department of Justice reported that 33 percent of the 274,564 State prison inmates were under the influence of illicit drugs at the time they committed their crimes. Half the inmate population had been daily users of some drug at some point in their lives with less than one-fifth having



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used heroin daily and about one-tenth had had daily cocaine use. The National Institute of Justice operates a drug use forecasting system that does urine testing of arrestees in the largest cities. Of males arrested in various cities between June and November of 1987, the range of those positive for illicit drug went from 53 percent for Phoenix to 79 percent for New York City. However, if the justice system [illegible]des to exploit the possibilities of treatment as a means of diversion, it can easily keep the current and proposed treatment slots filled. However, it should be recognized that not every criminal who has a drug abuse history is an appropriate candidate for treatment.

A new and potent means of inducing drug abusers to enter treatment is the aggressive outreach program currently being implemented for intravenous drug abusers in major urban areas. It is expected that within the next several years, 80 percent of untreated intravenous drug abusers can be contacted through this method of outreach. The impact on the treatment network should be substantial.

Interviews of over 10,000 active intravenous drug abusers who were not in treatment indicates that 59 percent have had a prior treatment experience. This finding demonstrates that treatment is popular among drug abusers and there is clearly a very large potential demand for drug abuse treatment services.

## HOW WELL DOES TREATMENT WORK?

Treatment can be highly effective in reducing illicit drug abuse and criminality, and increasing desirable behavior (school attendance, employment). However, like many other chronic disorders, drug abuse may require multiple episodes of treatment; and some will not be be helped by any of the currently existing forms of treatments. Further, long-term drug abuse rarely yields to short-term therapeutic interventions.

### Self-Help Groups

In self-help programs addicts act as resources to one another to help maintain their resolve to remain drug abstinent through continuing contact and regular meetings. Alcoholics Anonymous and Narcotics Anonymous are the best known examples of these groups. Recently, attempts have been made to bridge the gap between "pure" self-help approaches and more structured treatment regimen. One such attempt involves "professionally guided self-help," in which a professional acts as a facilitator in a series of skills training sessions used to give clients the intellectual resources to cope with those factors that precipitate relapse. In controlled tests of this approach, improvements were produced in skills to avoid drug and alcohol use, skills to cope with drug relapse, consequential thinking skills, and social skills. Self-help approaches can be an effective intervention for the moderately drug disabled or for those who have successfully completed a course of treatment and are simply in need of peer support.

### Detoxification

Detoxification is a procedure designed to render the patient drug free with a minimal level of discomfort or danger from life-threatening withdrawal symptoms. Detoxification from some drugs (e.g., opiates and barbiturates) is accomplished by giving decreasing doses of drug over a period of time. With others (e.g., marijuana and cocaine) drugs can be stopped abruptly. Depending on the nature and severity of the problem, detoxification can take place in an in-patient hospital setting, residential facility, or in an outpatient program.

Detoxification should only be considered a preliminary step in the treatment process, except for those who are only moderately involved in drug use. It does not deal with the psychological and social difficulties that contributed to the development of the drug abuse problem. Most studies comparing addicts before and after short-term detoxification, with no other intervention, have found little or no long-term decrease in drug-taking behavior.

### Residential Treatment and Therapeutic Communities

In these programs, clients live in a highly-structured setting. The programs are aimed at producing deep and permanent attitude and value changes as well as a commitment to a drug-free life. The duration of such programs varies from several months to two years. The shorter-term programs (Hazelden, Betty Ford Center) seem to be geared to older patients with fewer economic and psychological problems and little criminal involvement. They have evolved from programs aimed exclusively at those who abuse alcohol, to programs for treating sedative, cocaine, opiate, and cannabis dependence. Their utility

for treating the severely dependent, or culturally disadvantaged, or long-term heroin or cocaine users is uncertain. The traditional longer-term programs (Phoenix House, Daytop Village) evolved from programs originally aimed at younger, criminally involved hard-core illicit drug users. The short-term residential programs are usually far costlier, on a per day basis, than the longer term programs which in turn are about three times more costly than intensive outpatient programs.

The effectiveness of long-term programs has been well established. In one assessment; drug use, criminal involvement, and employment status were compared in drug abusers who completed treatment (graduates) and those who did not (dropouts). Graduates and dropouts showed few differences prior to treatment, but substantial differences at followup. Especially striking are decreases in opioid use (less than 5 percent of graduates reported any use of opioids during a five-year followup period, compared to 95 percent prior to treatment) and criminal involvement (81 percent of graduates reported criminal involvement at one year prior to treatment compared with 6 percent at three years after treatment). For dropouts, reductions in opioid use and criminal involvement were less dramatic, yet still substantial. Significant changes were also seen in the arrests, conviction rate, and months in jail and employment for graduates and dropouts.

The longer the drug abuser is in treatment, the more successful the outcome. The problem with long-term residential treatment is that the retention rate is low. The high dropout rate in therapeutic communities is at least partly related to initial program intensity, with new admissions having difficulty in adjusting to the strict rules of the community, being confronted by other residents about drug use, etc. In fact, dropouts are typically highest in therapeutic communities within the first 14 days of treatment. Recent research has resulted in techniques to improve retention in therapeutic communities.

### Drug-Free Outpatient Treatment

The drug-free outpatient modality includes a wide variety of approaches to treatment. It is the most widely used treatment modality accounting for about 40 percent of the drug abusers in treatment, many of whom are non-opiate drug abusers. Programs vary widely from casual drop-in centers to highly structured programs providing counseling and psychotherapy. They are called "drug-free" to distinguish them from outpatient programs that dispense methadone. As with residential treatment, drug-free outpatient treatment has been found effective in reducing opiate and nonopiate drug use, increasing employment, and decreasing criminal involvement. However, as with therapeutic communities, retaining hard-core drug abusers in treatment is a problem. In one study, only 20 percent of heroin addicts remained in drug-free outpatient programs for the recommended duration of treatment.

These evaluations were done prior to the development of new therapeutic techniques for preventing relapse. Relapse prevention techniques offer promise of increasing retention and making outpatient drug-free programs even more effective.

**Methadone Maintenance**

Methadone is a legal drug that can substitute for heroin and prevent opiate withdrawal symptoms. Administered orally, on a daily basis, it allows many opioid (heroin) addicts to function normally without constant craving for heroin. Methadone maintenance, in and of itself, cannot be considered rehabilitation. However, by reducing the physiological craving for heroin and the fear of withdrawal, the methadone maintained client is able to focus attention on work, family and rehabilitative activities.

Methadone maintenance programs typically operate on an outpatient basis, require medical supervision and provide both counseling and some general medical care. Methadone maintenance is readily accepted by a high proportion of heroin addicts and approximately 74,000 addicts are in treatment at any time. Retention rates are higher than in other modalities, with one-year retention rates ranging from 55 to 85 percent in different clinics.

Entry into methadone maintenance programs is associated with a dramatic reduction in illicit drug use and criminal behavior, and an increase in social adjustment and productivity. In a recent study of seven methadone maintenance programs in three cities, 66 percent of those who had recently entered the programs had used illicit opiate in the past month of treatment, whereas only 23 percent of those in treatment for 1-5 years and only 8 percent of those in treatment for 5 or more years showed similar evidence. In addition to reducing illicit opiate use, methadone maintenance has been found to reduce other types of drug use as well. However, abuse of other drugs such as alcohol or cocaine continues to be a problem, requiring the development of new approaches for these multiple drug abusers.

In addition to decreases in drug use, criminal activities decrease and productive activities increase during methadone maintenance. In one large scale evaluation, illegal income of heroin addicts declined threefold as a result of treatment. In the two months prior to treatment, 49 percent of clients derived income from illegal sources, while only 18 percent of clients had such income at any time during treatment.

Unfortunately, when clients terminate prematurely from methadone maintenance programs, they usually return to opiate use within several months. On the other hand, of those who relapse to heroin use, most subsequently reenter treatment.

Finally, it is clear that methadone maintenance can significantly reduce the transmission of AIDS among intravenous drug abusers. By reducing intravenous drug use, methadone maintenance is effective in reducing the sharing of contaminated needles. Indeed, one study in the New York area has reported markedly lower rates of seropositivity among heroin addicts in methadone maintenance programs (23 percent) than heroin addicts not in treatment (47 percent). Other studies have reported significantly lower seropositivity rates for addicts enrolled in methadone maintenance programs for several years than for addicts recently admitted to treatment programs.

In a recently published book summarizing the findings of the NIDA sponsored Treatment Outcome Prospective Study (TOPS), the largest and most comprehensive

study of the effectiveness of drug abuse treatment, Hubbard et al. stated:

> What is the overall effectiveness of drug abuse treatment? We considered this question both from the standpoint of reducing drug abuse and from the standpoint of building more productive lives (decreasing criminal activity, alcohol use, and depression, and increasing employment). Our most dramatic finding is that drug abuse treatment has been notably effective in reducing drug abuse up to five years after a single treatment episode. The major modalities have had more limited success in rebuilding the lives of drug abusers and reintegrating them into society.

## ADDICTION TREATMENT MEDICATIONS DEVELOPMENT

The provision by Congress, in the Anti-Drug Abuse Act of 1988, of supplemental funds for the development of new pharmacotherapeutic approaches to the treatment of drug abuse has enabled NIDA to make this effort one of its top research priorities. The reasons for this priority are obvious. The cost of drug abuse is staggering. Unfortunately, future costs in terms of lives and dollars will be even more burdensome with the spread of HIV/AIDS within the drug abusing population and with drug abusers serving as a source for the spread of the human immunodeficiency (HIV) virus into the heterosexual population. In addition, the enormity of the human tragedy resulting from fetal exposure to HIV and/or cocaine is increasingly being recognized. More than ever, there is a need for effective new medications as well as other new or traditional drug abuse treatments.

Drug abuse is a unique disease in which the individual seeks to alter, or indeed to "experiment" with, the functioning of the nervous system in an attempt to change how they feel and how they see the world. While the beginning stages of drug abuse can be seen as voluntary behavior, it is clear that drug addiction leads to fundamental changes in brain function such that the individual's focus is entirely dominated by obtaining and using drugs. One goal of treatment is to restore, to whatever degree possible, normal brain activity. From a biological perspective, the development of effective treatment strategies for drug abuse requires advances in knowledge of the neural bases of the individual components involved in this disease, such as craving, euphoria and dysphoria, compulsivity, learning and memory, risk-taking and sensation seeking, and tolerance and dependence.

Fortunately, significant progress has been made in unraveling the internal physiological processes mediating these behaviors. This knowledge gives us hope that we will be able to develop new, effective medications.

NIDA pointedly uses the word "medication" rather than "drug" development, for that is what we propose to develop. We have been unduly burdened by the fact that we do not have different words to refer to chemicals used for treatment as opposed to those being abused. Other languages, such as French, make this distinction quite clearly. Unfortunately, semantics sometimes get in the way of reality and there are those who say you should not use drugs to treat drug abuse. Nothing, of course, could be further from the truth. As was mentioned, NIDA will be developing therapies to restore some normality to brain function disrupted by the abuse of drugs. We will be using the word medication to help keep the approach and the distinction between abused drugs and medications clear.

Drug abuse research has led to fundamental insights into the understanding of drug-receptor interactions, the structure-activity relationships of drugs and the brain, and mechanisms underlying brain toxicity. With this information and utilizing state-of-the-science technological advances in a wide variety of areas including molecular biology, brain imaging techniques, and computer-aided medication design and modelling, we plan to develop medications that:

1) Are equally efficacious therapeutically but have less negative effects than those currently available (e.g., a non-addictive morphine substitute)
2) Block the behavioral and physiological effects of abused drugs
3) Reduce the craving for abused drugs
4) Moderate and/or eliminate the process of withdrawal
5) Block and/or reverse the toxic effects of abused drugs.

Unfortunately, the development of pharmacotherapies for the treatment of drug abuse has not received significant support from the pharmaceutical industry because of problems with either the marketability or the profitability of some medications. First, drug dependent people are a group of sick people who do not necessarily seek treatment and indeed, may actively avoid it. Thus, they may be seen as a limited potential market for anti-drug abuse medications. Research on this population is difficult and is not attractive to many investigators. Second, prior to the current cocaine epidemic, the number of drug abusers, while large, was not of sufficient size to be economically rewarding to pharmaceutical manufacturers since the profit potential of new treatments was not great. Furthermore, there is a belief in the pharmaceutical industry that both the distribution of and reimbursement for new medications are likely to be carefully controlled, further reducing their wide spread use. Third, some medications that could be developed are either off patent or about to come off patent. Lack of patent protection may significantly affect the profitability of new medications. Fourth, many pharmaceutical companies are concerned about having their product line and the company name associated with "junkies" in the public's mind. Fifth, many pharmaceutical companies are concerned that introducing a product into the drug abusing population will decrease the market for the product's other potential uses. The product, for example, may be placed in what is to them an unacceptable schedule under the Controlled Substances Act, or its use may be severely restricted, like methadone, which is a synthetic opiate used in the treatment of opiate dependence. Finally, pharmaceutical manufacturers are concerned about a whole variety of liability issues, some of which may be unique to drug abusers. While some of the concerns may be overrated, others are real. The liability associated with the development of treatment medications for pregnant drug abusers, for example, must be considered by even the most compassionate and concerned corporate officers.

The incentives of the Orphan Product Act, AIDS, and the size and demographics of the cocaine epidemic are factors serving to change this situation. We have been pleased to see in the past year significant interest in medications development for drug abuse from several pharmaceutical companies. It is nonetheless clear that significant Federal leadership is required in this area, leadership that the Department of Health and Human Services, ADAMHA, and NIDA plan to provide by a long-term commitment to the development of medications for the treatment of drug abuse.

A brief background on what has been done to date and what is planned for the future is as follows. NIDA had a small pharmaceutical development program in the 1970s and attempted to develop 2 medications, (L)-Alpha Acetylmethadol (LAAM) and naltrexone. As a result of a cooperative effort between the Federal government and the private sector (Dupont), one of those drugs, naltrexone, has an approved New Drug Application (NDA) and is now on the market. No pharmaceutical company was willing to develop LAAM, and we are

currently trying to find a contractor to develop this medication. The success or failure of our new pharmaceutical development program will be entirely dependent on our ability to establish cooperation and collaboration with the academic community on the one hand and the pharmaceutical industry on the other. We need the academic community to come up with new ideas and approaches to the treatment of drug abuse and we need the pharmaceutical industry for this reason as well as their expertise in the process of medications development.

Beginning this past year and continuing as a major priority, NIDA is establishing a research program specifically seeking to identify new medications for drug abuse treatment. We are quite mindful of the fact that many of the chemicals that will be identified and/or synthesized will, through their central nervous system actions, have potential value for other disease conditions and we are working closely with both the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health, and the National Institutes of Health so that these opportunities will not be lost. This effort is an evolving process but has several different aspects.

Compounds high on the list for evaluation will be derived from a comprehensive database that NIDA is developing about chemical entities which have central nervous system activity. The chemicals in the database will include pre-existing compounds as well as compounds developed on the basis of structure-function activity, computer-aided medication design, knowledge of receptor pharmacology, and knowledge of the functional bases of drug reward, euphoria, dysphoria, and dependance.

New potential medications that meet our basic pharmacological parameters for candidate treatment agents will then be evaluated for potential efficacy and safety in animal models. Specific relationships concerning the government role in testing and evaluation of compounds and the use of the data generated are being developed.

Three issues surrounding the potential toxicity of new compounds are of particular concern. First, since we will be dealing with medications that target the brain and in view of recent findings concerning the potential brain toxicity of a variety of drug classes, we will be paying particular attention to both the acute and long-term effects of candidate medications. Second, the medications that we are developing are being targeted at patients who because of their drug-related behaviors are either HIV seropositive or at high risk of exposure to HIV. We are particularly concerned about not exposing these people to anything that might accelerate the clinical course of the disease or increase the probability of clinical HIV infection. Given the limited knowledge of the natural history of AIDS and the role of co-factors in the disease, it is not clear how we will do this, but it is an area of significant priority that we are examining. Lastly, we are facing another unusual situation in developing medications for the treatment of drug abuse. Since the disease itself involves the self-administration of a drug which, in the case of cocaine, may produce a fatal acute reaction, and because a number of candidate treatment agents might potentiate these effects if taken with cocaine, the FDA has raised the issue of requiring drug interaction studies to show safety. Given the myriad potential interactions of drug, dose, method of administration, etc. possible, it is a very difficult problem to resolve. We are working closely with the FDA around this issue.

One problem common in medicine that is particularly critical in drug abuse therapy is patient compliance with treatment. To address this problem, NIDA will continue to expand its efforts to develop new long-acting dosage forms and dosage forms with limited abuse potential. Currently, research is being undertaken for the development of a clinically useful depot (i.e., long-acting) preparation of naltrexone to provide blockade for a period of one month in humans. Research is also being encouraged for oral muco-adhesive products, skin patches, and other delivery systems that will help patients stay on their medications and prevent diversion.

The abuse potential of some new medications may be modified by making preparations that are effective when swallowed and ineffective if they are ground up and injected. This can be done by formulating them into rapidly dissolving pills that cannot be "saved" in the mouth and later used for injection, or by a "binary" approach to treatment whereby two different medications are needed for the therapy to work. One part of this treatment could be carefully controlled in the clinic and the second part could be allowed for as home medication.

In terms of clinical trials, NIDA plans to establish dedicated clinical units for the sole purpose of evaluating new medications and conducting the necessary clinical trials for phases I and II of the medication development process. We also plan to establish master agreements with a variety of pharmaceutical firms who would agree to take promising new medications through phase III clinical trials, NDA application and approval, and market the medication in exchange for exclusive rights to the compound for the treatment of drug abuse. In other words, NIDA could, under some conditions, perform all necessary preclinical and phase I and phase II clinical studies and transfer these data to a pharmaceutical firm willing to complete the NDA process and market the medication. This approach has been used successfully before at both the National Cancer Institute and the National Institute of Neurological and Communicative Disorders and Stroke, and we are hopeful that it can work for us.

In the past year the Medications Development Program has gotten off to a rapid start and a number of priority medications are being investigated. First, there is methadone. Methadone is a very effective medication for the treatment of opiate addiction. It is an orally active replacement therapy for heroin which allows a former heroin addict to stabilize his or her life, hold a job and maintain family relationships, and receive appropriate psychological and vocational counselling. Nowhere is the success of this medication more clear than in the data showing differential HIV infection rates in those successfully maintained on methadone as opposed to those not in treatment. However, there is some public feeling against the use of methadone, so we are trying to develop alternative medications which we hope will improve the acceptability of agonist (replacement) therapy. We are renewing our efforts to develop LAAM (a long-acting opiate replacement drug with limited abuse potential) and are seeking a contractor to evaluate the existing data and determine what more has to be done to obtain an NDA for this agent so it can reach the marketplace.

Of perhaps greater interest is buprenorphine, a medication providing both agonist and antagonist (blocker) effects in a single dosage form, which is being actively studied both by extramural scientists and at NIDA's own

Addiction Research Center. Buprenorphine is a classic example of the difficulties of medications development in the treatment field. It is a potentially useful medication that the manufacturer is unwilling to develop for the treatment of drug abuse because of the possible adverse economic impact of such development. Without going much into further discussion of the proprietary problems associated with the medication, if its promise continues to be realized, NIDA will proceed with its development within the context of the new pharmacotherapeutics program.

Depot naltrexone has already been mentioned and we are looking forward to clinical trials in about a year and one half. Depot dosage forms of a variety of treatment medications may provide a powerful public health tool in the 90s.

Lastly, we are beginning to see some hopeful signs in regard to cocaine addiction treatment. Because of the enormously powerful biological dependence cocaine produces, research has preponderantly focused on the development of pharmacological interventions (medications) that will reduce craving and break the seemingly ineluctable sequence of quick relapse following detoxification. The strategy used in the investigation of these medications has been based on cocaine's theoretical mechanism of action on the human nervous system. When cocaine is administered, it has an effect on the brain that is subjectively experienced as euphoria. This results from an electrochemical effect on nerve and brain tissue. One physiological event seems central: The transmission of an impulse from one neuron to another neuron across the space separating them, the synapse. The neuro-transmitter dopamine is necessary for this transmission to occur. The dopamine is normally replenished by being retrieved from the synapse after the impulse transmission, a process called "re-uptake." Cocaine is believed to exert its main effects by blocking that re-uptake and hence augmenting dopamine present in the synapse. If this is done chronically, however, dopamine stores in the nerve terminals become depleted, a phenomenon believed to underlie withdrawal depression and craving when cocaine administration is stopped. This complex process is only partially understood and other transmitter systems may be involved, but fundamentally this is the neurochemical system at which pharmacological interventions have been aimed.

One approach has been to use tricyclic anti-depressants, which are believed to impact favorably on mood by normalizing dopaminergic balance through re-uptake blockade. In this class, imipramine, desipramine, and doxipen have been tried with some success in small groups of patients. The major scientifically controlled studies of desipramine at Yale University found that it was significantly better than lithium or placebo in prolonging initial abstinence and decreasing craving. Lithium, another mood normalizing medication believed to work at least in part via dopaminergic pathways, was no better than placebo. Early reports from two other clinical trials of desipramine have not found a positive effect, but their research designs and study populations are somewhat different.

Another general class of compounds being studied are the direct dopamine agonists, which are agents that presumably mimic dopamine and thus counteract the depletion induced by chronic cocaine use. L-Dopa, usually used for the brain dopamine depletion of Parkinsonism, does not appear to be effective for treating cocaine abuse. Methylphenidate, a medication used for childhood hyperactivity, is a stimulant that has been viewed as a possible "replacement"

drug for cocaine, much as methadone is a replacement for heroin. Experiments have shown a positive effect for the first few weeks of abstinence, but then the patients get much worse, possibly because methylphenidate's stimulative properties re-awaken cocaine craving. Methylphenidate has been used successfully in some adults with a clear history of childhood hyperactivity, but further work is necessary to determine whether it might still be useful for cocaine abuse in this specific sub-population. A stimulant considerably less potent than methylphenidate, mazindole, is under investigation, but no results are known at this preliminary date. Some small clinical trials have suggested efficacy for two other dopamine agonist, bromocriptine and amantadine (both used in Parkinsonism), and several larger, well-controlled trials are underway.

Another line of investigation has taken the view that medications quite opposite in action to the dopamimetic class might be useful, based on the notion that filling post-synaptic receptor sites would essentially block the effect of the cocaine-induced synaptic excess of dopamine. Small trials with two of the most commonly used dopamine blockers, chlorpromazine and haloperidol (both used widely in the treatment of psychotic disorders) have appeared to make the patients worse by augmenting withdrawal depression. However, one agent in this class, flupenthixol, has shown excellent results in an open trial. A larger, placebo-controlled study will shortly be started. A drawback of flupenthixol and dopamine-blockers like it is the potential to produce a serious movement disorder called tardive dyskinesia, which appears in some patients after longer-term dosing.

A variety of other agents are being tested on a small scale. Some are based on complex theoretical rationales relating to neural transmission, while other are given "empirically" because of their known psychoactive effects. The anti-convulsant carbamazepine, which is quite similar in structure to imipramine, has shown some promise in a non-placebo-controlled study of about 20 patients. Valproate, another commonly used anti-seizure medicine, will also be tested shortly. New anti-depressants such as fluoxitine and sertraline, believed to work primarily on another major transmitter system that utilizes the chemical serotonin, are under consideration, as are the cardiac drugs verapamil and diltiazem, which seem to block the euphoric effects of stimulants. Finally, mention should be made of buprenorphine, a mixed agonist/antagonist opioid originally developed as a maintenance agent that could provide an alternative to methadone for opiate addiction. A primate study has shown that buprenorphine can reduce cocaine self-administration. Small tentative clinical studies seem consistent with this finding.

In sum, the gravity of the cocaine crisis has been appreciated only for the last few years, and for this reason all the medications having possible potential for clinic use are in an experimental phase. However, there is some cause for cautious optimism, for two major reasons: 1) the scientific capability is available to screen literally thousands of active compounds for potential clinical efficacy, and 2) the field of neuroscience is making striking advances in understanding the complex physiology of the brain and its derangement by substances of abuse.

In conclusion, NIDA and ADAMHA are committed to this new program of medication development. Drug development is a long and expensive process, and success is

likely to be years, if not decades, away. However, even when new medications are developed and approved, we cannot fool ourselves into thinking that these will be "magic bullets." Drug abuse is a chronic, recurring disease more akin to arthritis and diabetes than to a broken arm or a simple infection. We are trying to treat and control the disease, and medications are a valuable part of that process. The medication may help the patient in the immediate physical sense, but comprehensive treatment involves counseling, therapy, vocational training, and other services. Someone, especially a young person, who loses years of life to drug addiction, is not going to be "normal" merely because he or she no longer takes drugs. Significant attention must be focused on that individual and the development of other effective treatments. Finally, and ultimately, we must ask ourselves what it is about contemporary society that has led to the demand and unfortunate level of societal acceptance of drug abuse and that must be corrected if we are to achieve success in ridding the Nation of this scourge. We must do all in our power to change this attitude of acceptance to an attitude of intolerance to drug abuse.

This completes my formal presentation. I will be happy to answer any questions you may have.

The CHAIRMAN. Has that been complicated because of the addictiveness of crack, too, which as I understand is more potent in terms of addiction than some of the other substances?

Dr. SCHUSTER. Absolutely. First of all let's make it clear that crack is cocaine, and cocaine is, by any route, one of the most addictive substances that we have ever seen. But the reason why crack is so particularly addictive is that when we smoke a drug, it very rapidly gets into the body, and even more rapidly than with an intravenous injection, gets into the brain at higher concentrations than if you were to inject it, say, in your arm.

Therefore, for the drug user who is taking the drug by smoking, he gets the immediate very high brain levels that are what is being sought because they get this immediate euphoric response.

Then, very quickly, the drug gets redistributed to the rest of the body, some of it comes out of the brain, and they go down again. Naturally, since they have been up at this pinnacle of euphoria, what do they want to do? Get back up there again.

So crack leads to episodes of multiple use, occurring as often as every 5 to 20 minutes, until you run out of money, and then you are willing to do anything in order to get the money or to get the drug.

The CHAIRMAN. Let me ask what is your estimate of the numbers of addicts in our country who need treatment?

Dr. SCHUSTER. Well, the estimates of course are just that—estimates. I think that we have to understand that after 1981 when the block grant mechanisms came in, we have lost a lot of data regarding treatment systems in the United States.

Fortunately with the 1988 Anti-Drug Abuse Act, the set-aside funds from the block grant will now allow us to get much better data to be able to give you answers to this. But there is no question at the present period of time that the estimates range from approximately four to six million people who are in need of treatment. And we know that only about 18 to 20 percent of them are in treatment at any one time.

The CHAIRMAN. Could you give us some idea as to the demand for treatment, and what are the waiting times?

Dr. SCHUSTER. Well, there have been studies that have been done on waiting lists in the United States, and it varies from community to community. But at least for certain types of treatment programs, waiting lists can be as long as 6 months.

We know that there are certain types of treatments that are more popular than others. So, for example, for heroin addicts, methadone maintenance is a more acceptable form of treatment than a drug-free treatment. So the utilization capacity of methadone maintenance treatment programs is very high in comparison to, say, drug-free outpatient, where there is less utilization of that capacity.

The CHAIRMAN. How do you respond to those who say that when you are doing methadone maintenance, you are really just substituting one drug for another?

Dr. SCHUSTER. I am very pleased to answer that question. First of all, I think you have to understand that methadone maintenance is appropriate for people who have had their brain and their body exposed to a drug called heroin for a long period of time. We know

that exposure to this drug for a long period of time causes long-term and perhaps even irreversible changes to the brain, making it virtually impossible for some individuals to become totally free of an opiate.

Methadone is a medication that only has to be taken once daily by mouth, and the individual's need for the opiate is satisfied.

I think what is of importance is that because of the fact that they are not going up and down as they do when they are injecting a drug like heroin, which only last for four to six hours and they need another injection, methadone maintains a steady state so that the are now no longer preoccupied with getting the next dose of the drug or getting high from the last one, because it is a steady state. It provides a window of opportunity for the other forms of rehabilitation to be able to occur, so people can now become concerned about the family that they have left behind because of their addiction; they can become concerned about what am I going to do with the rest of my life.

And I can tell you that many people who are in highly-responsible positions in our country have been maintained on methadone for many years and are effective citizens, working every day, with their families, and in every other way except for the fact that they need to take this medication are as normal as you or I.

The CHAIRMAN. Can you give us some evaluation of the different types of treatment—outpatient, residential, and so on.

Dr. SCHUSTER. Well, obviously, sir, it depends upon the individual. When you talk about drug abuse treatment you have to recognize that it varies in terms of its intensity from those people who have just begun to take drugs, but they are concerned about it, and they need a little help to get off. Oftentimes workplace programs can be effective there; counselors and EAPs, etc. Drug testing programs in the workplace may be sufficient to deter them from continuing to use drugs.

At the other extreme we have people who have other psychiatric disorders, who have very poor job skills, who have very poor interpersonal relations, and who have been on drugs for many, many years. So we have to talk about the range of intensity of these problems and the other aspects of this individual's dysfunctionalness.

Let me just summarize by saying that for heroin addiction there is no question that methadone maintenance overall is the most cost-effective treatment program, period. On the other hand, for younger people who have just begin a career of drug use, therapeutic communities can be extremely effective. The problem with therapeutic communities has been that they have had high dropout rates, but for those who stay, they have shown marked decreases in illicit drug use, marked decreases in crime and an increase in prosocial behaviors.

Unfortunately, the dropout rates can be as high as 85 percent. That is improving. The therapeutic communities are now attempting to do research to improve their retention rates, and there has been a recent report by Dr. George de Leon showing that they are able to do this, and we are encouraged by that and hope that that mode will be increasingly effective.

Outpatient detoxification and drug-free programs also suffer from very heavy dropout rates, and we are again trying to do research to improve their ability to retain people in treatment.

I think we have to recognize that to really be effective in terms of drug treatment, we must keep people in treatment for a long period of time. I favor wherever possible a carrot-and-stick approach. For individuals who have run afoul of the criminal justice system, I think it is very appropriate in pre-trial diversion that they are mandated to go into treatment. But the stick has to be there that if they drop out of treatment there will be some consequences for this. And it is my understanding that because of the shortage of jail cells and other problems that there is no longer any stick to keep people in treatment. And I would point out that people who are in treatment on a mandatory basis do as well if they stay as those who came in voluntarily.

So any way we can keep them in treatment, I would favor.

So I would say that we need a composite of increased law enforcement capability to keep that stick there, at the same time as we are offering them the carrot of rehabilitation.

The CHAIRMAN. My time is almost up. Do you have suggestions on how to improve the treatment retention rates?

Dr. SCHUSTER. Yes. Specifically, one of the things that I think is absolutely essential is that we have to increase the training of the drug abuse counselors who are in the treatment programs.

It is a tragedy—and I have said this many times—but I was in Philadelphia recently and saw an advertisement in the *Philadelphia Inquirer*: "Wanted: Drug abuse counselors. No experience necessary. Twelve thousand dollars a year."

I would submit to you that those individuals are not going to be effective in engaging people and helping them to carve out a new lifestyle. We need training for these people, and we need adequate salaries for them so that they will stay in the publicly-funded treatment programs and not be sucked off into the private sector where, of course, they can make more money.

So I think the No. 1 thing that our research has shown is that the adequacy of the training and the experience of the drug abuse counselors would improve retention rates.

The CHAIRMAN. Where are some of the best treatment facilities or programs; could you mention some of those, or do you want to supply them for the record?

Dr. SCHUSTER. I would be happy to supply them for the record.

I would say to you that our recent studies have shown that there is great variance; that some treatment programs at the end of a year after a person comes in, only 7 percent of the people are still taking illicit drugs; in other treatment programs it can be as high as 55–60 percent are still taking illicit drugs. So they vary. And that is one of the things that we are very concerned about. The variance, we think, is because of two things—this was methadone maintenance treatment programs—first, inadequate doses of methadone because of a prejudice against this medication, and second, inadequately-trained counselors. Those were the two factors. But there are very good treatment programs, and we'd be happy to provide you some of the names of those.

The CHAIRMAN. Yes, if you would, please, because it would be helpful for us to try and review those programs and see what lessons can be learned.

Senator Hatch.

Senator HATCH. Thank you, Senator Kennedy.

As I understand it, crack cocaine is addictive from the first use of it; it is emotionally addictive, and then it becomes physically addictive with each subsequent use—is that correct?

Dr. SCHUSTER. Well, I would say that for vulnerable, susceptible individuals, this is true. The reason why I say that is that there are people who have tried crack cocaine who do not inexorably go on to becoming addicted. But let's just say if ten people try it, perhaps as many as five or six will go on to chronic regular abuse, in comparison to alcohol or other drugs where perhaps only one in ten becomes a problem.

Senator HATCH. In a good 80 percent of them there is some underlying emotional or psychiatric problem.

Dr. SCHUSTER. Yes, that's very possible.

Senator HATCH. This new methamphetamine they call "ice"—would you tell the committee what you know about its use?

Dr. SCHUSTER. Yes, right. Let me say that I think one of the long-term tragedies associated with crack use is the fact that the public has learned that you can smoke a drug that looks like a crystal. I think most of us intuitively would know you can smoke a weed, because we have smoked tobacco or we have seen people smoke tobacco, so marijuana smoking makes sense. But the idea that you could take something that looks like sugar, a crystal, and smoke it, I don't think is very obvious to most people.

Now that they have found out that crack, which is a crystal, can be smoked, my fear is that many other forms of drugs which are smokable will be smoked and that the population that is willing to smoke a drug is much larger than those who are willing to put a needle in their arm. And as I pointed out before, smoking a drug is as if not more addictive than taking it intravenously.

Senator HATCH. That is interesting. Clearly, residential treatment is more costly and more difficult than outpatient treatment. Can you tell us the relative costs of the two?

Dr. SCHUSTER. Well, if we look at the cost of inpatient treatment, even there they vary depending upon whether or not it is private or public, but inpatient can cost as much as around $31,000 a year on the average, whereas outpatient is about $1,900.

However, I have to point out that there are residential programs that do not involve hospitals, because it is not necessary for many individuals who need treatment for drug abuse that they be in a hospital; they can be in other kinds of residential facilities, and those are less expensive.

The main thing is that if you are going to get this disordered brain back into equilibrium—it has been disordered because of the contact with these poisons that they have been taking—it takes time, and we need to have people in a drug-free environment.

Now, our medication development program is designed to find medications that will even make that process more rapid, that is, get this disordered brain chemistry back into normal equilibrium,

with the hope that that will decrease craving and therefore relapse the drug use.

Senator HATCH. Clearly, drug development is a lengthy process, followed by FDA approval. How long do you think we are going to have to wait until we have new drugs come on the market that might be of some help to some very serious addictions? You have mentioned methadone. What about some of the others?

Dr. SCHUSTER. Well, we have a number of medications that are at various stages of development, all the way from those that are in animal research, which show a great deal of promise, to those that are already in the clinic.

I would say that we have at least two that are of interest that are going to be very rapidly brought into the clinic, and that is a special preparation of naltrexone, which is a narcotic antagonist, which we are developing in a depot form; it can be injected and will last for 30 days. For that 30-day period, the individual cannot get an effect from heroin.

Second, we have a new medication called buprenorphine, which we are very excited about because it is an excellent drug, we believe, for treatment of heroin addiction, but now there is some animal research which indicates that it may be useful for the treatment of cocaine addiction, and there are now also some human studies that are supporting this.

If this turned out to be true, it would truly be a miracle because this drug would be effective in treating those who are concomitantly using both opiates and cocaine, which is a tragically common phenomenon.

Senator HATCH. In your prepared statement you indicate a need to change our Nation's attitude of acceptance to an attitude of intolerance to drug abuse. Could you please describe for us how you think we can best achieve that particular objective?

Dr. SCHUSTER. For one thing, I think all of us in our own private lives have to get the message that when our friends or others around us are engaging in behaviors that we think are inappropriate, we've got to have the guts to say, "Hey, you know, that's dumb, and it's wrong, and you are my friend, and I'm really concerned about you, and I don't want you to be doing it if you want to stay my friend."

Second, I think that we are becoming much more effective with our mass media campaigns. I am pleased to say that the media Advertising Partnership for a Drug-Free America, which puts on many of the ads which you see on television, is not only doing that, but they also are evaluating the impact of this on attitudes. And I can tell you that they have shown a highly significant correlation between the areas of the country where these advertisements have been shown at a high frequency and attitudinal change. So they are being effective. And that, incidentally, is private sector free enterprise because that is all donated services.

Senator HATCH. That is interesting. I was with the National Board of Criminal Defense Lawyers a week or so ago, and a number of them raised the issue that they thought the only answer is to decriminalize the use of drugs. As an expert, what is your attitude about that?

Dr. SCHUSTER. Well, I can understand that if we are only concerned with taking the profit out of drugs that perhaps there might be some merit in that argument. But my concern is that with a drug particularly like cocaine, which is one of the Nation's number one problems, I don't see any way of decriminalizing or legalizing cocaine, and let me briefly explain why.

If you take an individual who is a cocaine user, and they come into a clinic/laboratory setting, and you ask them—they haven't had cocaine yet that day—"How much do you crave cocaine on a scale of zero to ten?" and they say "Four." You then give them a snort of cocaine or an injection of cocaine, and 15 minutes later you ask them again, "How much do you crave cocaine?"—now it is ten-plus, because cocaine has the capacity to stimulate craving rather than satisfy the individual.

Now, if you think about that, how are you going to legalize a drug which the more you take the more you want until you get up to toxic dosages? And I can tell you that people who happen to get hold of a whole bunch of cocaine and get into one of these drug binges only quit when they are dead or when they run out of drug. It is impossible to control.

So I don't know how you would legalize it. Who would give the person this amount of drug? It doesn't make any sense.

Senator HATCH. You would also have the problem of the people always bringing out more pure drugs like this methamphetamine that they are talking about in the news today.

Dr. SCHUSTER. Right.

Senator HATCH. I don't see how it can work. But, you get those kinds of, I think, superficial and ill-thought-about solutions. I don't think that legalization is a solution.

Let me just ask one last question. That is, it is one thing to provide treatment for those who are in schools and who are being at least touched every day by professionally-trained, teachers. How do you reach those who are not in schools and most likely to use drugs?

Dr. SCHUSTER. Well, we have had a very large outreach program, in this case in association with trying to get intravenous drug users and their sexual partners to stop using drugs intravenously in order to deal with the problem of the spread of HIV infection. But I can tell you we can get out there and get to this population.

Let me give you an illustration. In the State of New Jersey, they used ex-addict street workers to go out and give coupons out to 1,000 people who were not in treatment. The coupons said you can use this to come into treatment any time. Eighty percent of those coupons were used.

So you can have outreach programs that are very cost-effective because the ex-addict street worker who is trained to do this, he knows where to go on the street, he knows where the drug users are, he knows where these neighborhoods are, and he has credibility and acceptance there, and they can be used very effectively.

Senator HATCH. That's great.

Doctor, I want to compliment you for your leadership in this area, your knowledge and expertise, and for the really detailed statement that you have given to the committee today. We are very appreciative to have that kind of help here, and we appreciate

what you are doing and what Dr. Goodwin and others are doing at ADAMHA. We think that the Alcohol, Drug Abuse and Mental Health Administration is crucial to this country, and it is time people really understand that, and especially in the area that you work.

So we are very grateful for your efforts and thank you for being here.

Dr. SCHUSTER. Thank you very much, Senator Hatch.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you, Mr. Chairman.

For those who have to wait for treatment, a problem that you mentioned, it seems to me there are two problems. One is you discourage others from signing up. You go back to your fellow addicts, and you say, "I have signed up; it is a 4-month wait."

Dr. SCHUSTER. Right.

Senator SIMON. Second, what do you do in the meantime to sustain your habit?

Now, I have talked to some people from New Jersey, and they say it is a 7-month wait; I've talked to some people in Chicago, and they give me different figures. Is it possible for you or for anyone to, once a year, give a report to Congress or to the President or to someone that is made public, that says here are the waiting periods around the Nation and give attention to it? I think then maybe we could get some action.

Dr. SCHUSTER. The answer is yes, we can do that. Now, because of the 1988 Anti-Drug Abuse Act, the States are being charged with helping us to collect just that kind of data. But I would say to you that waiting lists are very deceptive in the sense that you have already said. If the word goes out onto the street that there is a four-week waiting list, people don't come in to sign up.

In Chicago, which is where I came from before I came to Washington, I have talked with the people there; they get a call on the phone and they say, "Don't even bother coming in." So that name isn't even recorded on a waiting list. They say, "Call back in another week or two, and we'll let you know whether it is worthwhile your coming in."

So it would be a gross underestimate of the number of people who would be willing to come into treatment if treatment were available at that time.

Senator SIMON. But at least some kind of indication to the public——

Dr. SCHUSTER. Yes.

Senator SIMON [continuing]. It seems to me would be a healthy thing.

Dr. SCHUSTER. I agree.

Senator SIMON. Do you need some kind of mandate from Congress, or is just this request good enough so that once a year you can do this?

Dr. SCHUSTER. I think that the data that we are now collecting from both NDATUS, which is the National Drug Abuse Treatment Unit Survey, will include that kind of data, and that we are going to be doing on a yearly basis.

Senator SIMON. So that you don't need a request from Senator Kennedy or this committee to once a year be doing this; you are going to be doing that and making it public.

Dr. SCHUSTER. Yes, sir. We will be doing that, but it is always helpful for us to have the stamp of—not approval—but the need that you feel will help us in order to be able to continue that activity.

Senator SIMON. OK. Mr. Chairman, I would suggest that we get a letter maybe signed by you and Senator Hatch saying this is something we request once a year.

Now, when I talk to addicts who are in treatment in Chicago, one of the things they tell me—and I don't know whether they are—in a sense they are experts, in a sense maybe they are not—but they say we have too many 30-day treatment kind of places, that real treatment for a lot of people takes longer than 30 days.

Do you have any comment?

Dr. SCHUSTER. I couldn't agree more. If you have an individual who has not only been addicted to a drug but has developed a lifestyle involving crime, has no job skills, etc., the idea of having a major impact on their life in 30 days is really absurd.

Clearly, 30-day programs which are involved with detoxification, that is, getting them off the drug, if they are properly linked up then with outpatient treatment that will be continuous, that can be effective. But unfortunately many times people think it is just the 30-day program that is effective, and that is really quite unrealistic, totally unrealistic. We are collecting data about that right now and hope to be able to publicize it.

Senator SIMON. In your more lengthy statement you talk about the number of lifetime users of cocaine was 21.2 million in 1988. When you use the phrase "lifetime user", do you mean someone who at any point in his or her life——

Dr. SCHUSTER. Has tried cocaine at least once.

Senator SIMON. OK. And then the other interesting statistic is that you say the overall rate of current use is 1.5 percent, and then you go into the various breakdowns. The highest use of any category is the unemployed.

Dr. SCHUSTER. Correct.

Senator SIMON. So that if we have programs to deal with pockets of unemployment in this Nation, are we dealing with the problem of drug use or is it the chicken and the egg——

Dr. SCHUSTER. Well, let me say this. The studies that I know of which have been done indicate that those individuals who are coming to treatment and who are able to find employment, the long-term outcome for them is far better than for those individuals who are not able to find employment.

Therefore, I would say that it is a very integral part of the rehabilitation; that if an individual doesn't have something to get up in the morning to go to that is meaningful and significant for them, if they are just going to be hanging out all day long, the chance of them relapsing to drug use is very high.

It may sound simplistic, but the opportunity is simply much greater, and the feeling of why not, because what else is there in this life. So we need to find work and meaningful work.

Senator SIMON. I think that is a very significant thing, and I think in terms of encouraging us to move in these areas, and those very areas of pockets of poverty, just judging by my State of Illinois, are clearly the very areas—and your statistics reinforce that—where we do have high and intensive use and high crime rates.

Dr. SCHUSTER. Right.

Senator SIMON. I have no other questions, Mr. Chairman, other than to note that I think the witness and I ought to really go into the book publishing field; there is a kind of a good ring to "Simon and Schuster". [Laughter.]

The CHAIRMAN. Senator Coats.

Senator COATS. Dr. Schuster, thank you for your testimony.

[Prepared opening statement of Senator Coats follows.]

PREPARED OPENING STATEMENT OF SENATOR COATS

Senator COATS. Thank you, Mr. Chairman. During the recent Senate recess, I had the opportunity to hold two subcommittee hearings in Indiana—one on the issue of drugs and infant mortality, another of law enforcement. In addition, we sponsored two conferences highlighting successful local drug prevention programs in Hoosier schools. The experience was encouraging and eye-opening. I found local communities that were engaged and active, as well as volunteers who were informed and effective. People have taken the spread of addiction and drug violence with all the seriousness it demands. And they are beginning to see some progress in their efforts to fight it.

I came away from these presentations and discussions confirmed in the belief that there are three keys to fighting drug abuse, none of which can be ignored. First, through aggressive education and prevention, we must raise a drug-free standard that admits no exceptions, particularly among the young. Second, we must enforce that standard, through law enforcement, on both pushers and users. And third, we must offer compassionate rehabilitation to those who fail the standard, without excusing their actions.

Our goal must be to offer hope without condoning abuse, providing help to the millions of Americans who find drugs, for whatever reason, taking control of their personal and professional lives, as well as making innocent victims of their families.

The Senate has recognized both this social need and our political responsibility. We've offered addicted individuals greater funding through the alcohol, drug abuse,and mental health block grant. Now we must begin to make sure that these additional funds are used to support treatment programs that actually work. This kind of oversight is required in the cause of good government, making sure scarce resources are well spent. But it is also required in the cause of compassionate government, preventing addicts from returning to the cycle of abuse, addiction and despair.

The problem of treating addiction is complex, for the simple reason that the causes of addiction are complex. Sometimes we find ourselves only treating symptoms. There is no quick cure for the conditions that seem to breed abuse—illiteracy, crime, delinquency, and, above all, the absence of stable families. But as past hearings

have shown, we can begin to make progress at the point where knowledge and resources converge.

Mr. Chairman, I look forward to working with you during this series of hearings on treatment and prevention. There is a great deal of work to be done, but I feel that we are moving in a positive direction by scheduling these hearings and having such excellent panelists as we have today.

Dr. Schuster, I just have a couple of areas I want to pursue.

First you gave the figure that roughly inpatient treatment—I assume which would be comprehensive treatment involving psychiatric care and so forth—is running $30-$31,000 a year, and outpatient treatment around $1,900 a year.

Clearly, with a 4 to 6 million person estimate of those needing treatment, if we were to engage in a massive Federal-State effort to provide comprehensive treatment, the kind that could deal with those underlying psychological and psychiatric disorders and so forth, we are talking about staggering amounts of money. And then, having said that, we are looking at a situation where half or more of those in treatment will drop out at some point.

Dr. SCHUSTER. Yes. I would simply say to you that we have to also look at what the costs are for failure to treat. If we simply look at the estimated number of individuals who are sero-positive for the AIDS virus because of their continued drug use, intravenous drug use in this case, and the fact that each of them is going to cost approximately somewhere in the range of $75,000 to $100,000 for the medical costs, then the costs of treatment, you can start to put in proper perspective. And I'm simply there just talking about one disease. I am not talking about the fact that a heroin addict by virtue of their criminal behavior costs society an estimated $55,000 per year.

So I think it is very difficult to look—one thing I've learned since I've been in Washington is you can't look at things over decades in terms of financial planning. But it seems to me that if we are successful even with the percentage that we are now—and I think we can improve that, incidentally—it is still cost-effective if we look at the cost of failure to treat over the next decade.

Senator COATS. But clearly—and I think you have hit on it here in your statement, that ultimately we have to look at what it is about contemporary society that leads to the addiction—clearly, the ability of the Nation to simply solve this problem through treatment—and I think we all recognize that those victims need the help, and we've got to try to provide the help—clearly, the answer has to lie in ultimately changing societal attitudes about this to the point where we don't have to get to the treatment stage.

I am wondering if—and I know Senator Hatch touched on this question—but I am wondering if you could elaborate a little bit about what it is in contemporary society that leads—what have you learned in your treatment programs and your psychiatric counseling and so forth as to what are those factors out there in contemporary society that are leading to that kind of thing?

Dr. SCHUSTER. Well, I think it is a mixture of social, cultural and biological factors. First of all, I think it is obvious that back in the 1960's and 1970's, it was virtually an accepted fact that adolescents

were going to smoke marijuana. I will say this. I was a professor——

Senator COATS. Or that cocaine was an acceptable, recreational, weekend activity.

Dr. SCHUSTER. A harmless recreational activity, exactly, exactly.

So we had not just a passive attitude of acceptance. We had, through the media, through music, through the glamorization in television and movies, active forces that were essentially selling illicit drug use at that time.

Senator COATS. And that is changing.

Dr. SCHUSTER. That has changed, absolutely.

I am pleased to say that we go very often to Hollywood as technical experts and talk to some of the producers and to the writers in an attempt to simply get them to portray these things realistically. Sure, you know, there is no question that when people first snort cocaine, they do feel euphoric, they do feel "up", they are more energetic. All those things are true. But you don't just show that. You also show the down side. And that is what is essential.

Second, I think you also have to note that we are uncovering in the same way as there are vulnerabilities in the area of alcoholism, and I am sure you are aware that at least for certain types of alcoholics, there are genetic bases for the predisposition for alcoholism, we are just beginning to get into the area with other forms of drug abuse. And although the evidence is not as strong, we do know that we can identify children at a very early age, the ages of three to four to five, who have certain behavioral characteristics that allow us to predict that they have a much greater probability of going on to be substance abusers than children who do not have these characteristics, and we are beginning to not only do the research on identifying them but seeing how we can intervene in that process to prevent that inexorable playing out of this developmental disorder.

So I think we are making progress.

Senator COATS. I didn't have an opportunity to read your statement, and I'm sorry that I missed it—have you listed those characteristics? Are those defined enough to——

Dr. SCHUSTER. Yes. They are not in this testimony, but I would be happy to provide them to you. Briefly, the kinds of studies that I am talking about are those that have indicated that in young male children, the two attributes of shyness—that is, failure to interact with other children in their social environment—and hyper-aggressiveness—that is, if they get pushed, they really lash out—those two characteristics—I started to say improve the prediction. What I mean is that the probability that they will become substance abusers in adolescence is about two and a half times greater than young males who do not have those two characteristics.

And a third characteristic—I am sorry—that also plays into this is failure to learn to read in the first grade.

Those three things increase the probability of a child being a dropout and being a substance abuser are very high, and we are now working on how we intervene in the first grade and the second grade and the third grade to turn this around, to decrease the shyness and aggressiveness and assure that these children learn to read early enough so that school becomes a positive force for them.

Senator COATS. Have you determined whether or not those characteristics are biological, genetic, or are they environmental?

Dr. SCHUSTER. That is what we are working on. We know from some studies that they are there in nursery school. And when you start pushing it back down that close, to children that young, I believe and my hunch is that this is going to be a strong biological component of this.

Senator COATS. Some people say it is the result of a lack of bonding that doesn't take place in early childhood, broken families, alienation, loneliness.

Dr. SCHUSTER. I wouldn't argue that those also can be factors.

Senator COATS. Of course, that's a significant change in societies—the family of today is considerably different than the family of the Fifties and the Forties and so forth.

Dr. SCHUSTER. Absolutely. Let me just tell you that there has been a recent report, an animal study, that I think is fascinating. If you take young rat pups who are still nursing, but you simply remove them from the mother for one hour per day during the first week weeks of life—now, they are obviously getting enough food, and they are not in any way biologically impaired, except for the fact that as adults, because of this experience, their brain chemistry is different than control animals who were not removed for one hour each day.

Now, I'm not saying that that necessarily makes them more prone to drug addiction; we don't know that yet. But the fact that something as simple as one hour a day stress being separated from their parent indicates that things such as you are discussing, the failure to bond, etc., because we do know that many drug users have children who are neglected and abused.

Senator COATS. My time is up. I'd like to spend an hour with you, but thank you very much for your testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I guess I too was touched by your, what I thought seemed to be an oversimplified, comparison of the $31,000 per year inpatient and the $1,900 year outpatient cost. That just cries out for explanation, I guess.

I take it $31,000 per year for inpatient treatment is for somebody who is either severely disabled or extremely disabled or has some kind of multiple diagnosis. What is it?

Dr. SCHUSTER. I may be cynical, sir, but it is probably for those who have third-party coverage that allows it to be paid.

Senator DURENBERGER. That's why I ask the question. Is that part of the explanation?

Dr. SCHUSTER. I think that it is, yes.

Senator DURENBERGER. The exceptions that we build into even some of our Medicare programs now for psychiatric hospitals, I suppose that helps foster that kind of a figure. So would it be fair to say that it would be unfair for this committee to draw conclusions from that $31,000 figure that that is what it has to cost?

Dr. SCHUSTER. Absolutely. I would not say that we need $31,000 treatment slots for every drug addict in the United States; no, sir.

Senator DURENBERGER. Thank you. Now at the other end, the $1,900 outpatient, what does that represent?

Dr. SCHUSTER. Well, there are many good treatment programs that could function on that amount of money depending upon the nature of the clients that they are dealing with. If they are dealing with those individuals who, for example, have gone through a good 30-day program, a residential facility, and then this is just a form of aftercare to allow them to come back into their own community but still with contact with a treatment program that is going to help them to carve out a drug-free lifestyle, that $1,900 or $2,000 might be appropriate.

If, on the other hand, we expect this to really be an adequate treatment program, a total treatment program, then it probably will not be.

Senator DURENBERGER. One of the most important areas—we are concerned not only about solving the problem but the cost of solving the problem, which obviously we have to deal with here. The ability of society reduced to some sort of a community definition to do as accurate as possible a job of diagnosis—isn't that today sort of a critical need that we have?

Dr. SCHUSTER. Yes. I think one of the big needs which we have particularly in our larger cities is what I would call diagnostic and referral centers. This is important for several reasons. First of all, it allows us to appropriately send people to the most appropriate type of treatment facility—those with psychiatric disorders in addition to their substance abuse disorder should be placed in the hands of appropriate professionals.

It also will allow better utilization of the existing facilities that are there, because as it is now in many cities, an addict wanders around and tries to find a place where he can get into treatment, and there is no central facility that knows what the resources are, what the availability is, and can make appropriate referrals.

So we are strongly recommending to the States and to the cities that they set up these diagnostic and referral centers. We are actually going to be assisting the District of Columbia in the next year in setting up a diagnostic and referral center here in the District.

Senator DURENBERGER. Thank you.

Mr. Chairman, I have a statement and some questions that I will submit in writing.

The CHAIRMAN. We will include that in the record.

[The prepared statement of Senator Durenberger follows:]

PREPARED STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Mr. Chairman, I want to thank you for holding this hearing today on a subject that I believe provides a critical—if not the critical—link to winning the war on drugs. No matter how tough we get on drug traffickers, kingpins, or users themselves, there will always be a need for effective treatment programs to help those who have fallen victim of drug or alcohol addiction recover from their habit.

I view this problem as a health care problem—one that needs to be treated just as cancer and heart diseases are treated. I am very fortunate to come from a State that recognizes the importance of

treatment. In fact, as you will her later this morning from Peter Bell, Minnesota has lead the way in this country in providing innovative and effective solutions in the area of treatment. Peter Bell has truly influenced my and many others thinking about what we are doing—or not doing—in the area of treatment.

Peter Bell is currently the co-founder and current executive director of the Institute on Black Chemical Abuse which serves over 12,000 black men and women. His message has crossed all political spectrums. During the recent furry within the Senate over drugs, Peter's advise was sought not only by the distinguished Chairman of this committee but also by President Bush, and Drug Czar William Bennett for his perspective on drugs. For his work that week he was named ABC News' Person of the Week. Among his numerous honors and distinctions, Mr. Bell has served as a Reagan Appointee to the White House Conference on a Drug-Free America and was recently appointed to the congressionally created National Commission on Drug-Free Schools.

I am particularly interested in the idea that Mr. Bell and others in my State advocate about the need to build a long-term treatment structure which includes prevention, post-prevention pretreatment, treatment, and after care. If we are to truly reach the hardest to serve and chronic substance abusers we will need a long-term, comprehensive approach. It wouldn't make sense to perform open heart surgery on a patient and release him from the hospital the next day thinking that patient had been cured. Nor does it make sense to think we can release a patient from treatment and think he or she will be cured. Surgery needs to be followed up by a comprehensive long-term plan for rehabilitation.

Mr. Chairman, there are no quick solutions to this problem. Progress will come only when we reach into the lives of every American and change the way we think about drugs, and only when we acknowledge the underlying causes of substance abuse. Only then will we be able to adequately treat those suffering from addiction.

I thank the Chairman for his commitment to this issue and for bringing before us today this distinguished panel of witnesses.

The CHAIRMAN. I don't know if you are familiar with the action that the Senate took in establishing an additional title similar to the Orphan Drug Bill to try and encourage research in this area for drug companies to deal with this. First of all, are you familiar with it, and second, your opinion of it.

Dr. SCHUSTER. Yes, I am, sir. I think it is extremely important. The pharmaceutical firms that we have talked to have uniformly said that the exclusivity in terms of the marketing rights that are provided, I believe for a 5-year period by the Orphan Drug Act, is a major incentive for them to become involved in the large investments that are necessary to bring a drug of this sort to market.

Developing medications for the treatment of addicts is not a very attractive proposition to pharmaceutical firms, and they need all the incentives that they can get. I do believe that extending that coverage to addictive disorders is very important.

The CHAIRMAN. Thank you very much, Dr. Schuster, for your very helpful and interesting testimony.

Dr. SCHUSTER. Thank you.

The CHAIRMAN. Our next panel includes Peter Bell and Pete Shrader. Peter Bell is the executive director of the Institute on Black Chemical Abuse and a nationally known authority on drug abuse treatment and prevention. He has been very generous in sharing his insights with me and other members of the committee, and we are delighted to see you and welcome you to our hearing today.

And we are glad to have Pete Shrader here as well. We are familiar with your story, and we hope that you will feel comfortable and relaxed, because you are among friends, and we are very delighted to have you here.

Senator DURENBERGER. Mr. Chairman, could I just insert in the record at this point an article from the *Star Tribune* about Peter Bell? For those of you who don't know him in the audience, Peter is only 38 years old. When he was 23, he started the Institute on Black Chemical Abuse, and maybe in part because when he was 22 he came out of a treatment program for alcohol, cocaine, heroin, and his life since then has led him to the point where he is an advisor to the chair of this committee, to many of the rest of us, to President Reagan and President Bush, and others. I think that is the kind of life that maybe Pete Shrader and a lot of other young people have ahead of them. So I am very grateful to you, Mr. Chairman, for giving me the chance to say that about Peter Bell, not just because he is a great resource in our community, but I think he is and will be in the future quite an example to a lot of other young people in America.

The CHAIRMAN. Mr. Bell.

## STATEMENTS OF PETER BELL, EXECUTIVE DIRECTOR, INSTITUTE ON BLACK CHEMICAL ABUSE, MINNEAPOLIS, MN, AND MILTON "PETE" SHRADER, STUDENT, T.C. WILLIAMS HIGH SCHOOL, ALEXANDRIA, VA, ACCOMPANIED BY HIS MOTHER, CONNIE PULLIAM

Mr. BELL. Senator, thank you very much.

I appreciate the opportunity to come before you this morning to share with you some of the concerns I have about drug abuse as it impacts this Nation.

In addressing drug abuse in this country, we must resist the temptation, I believe, to focus on what I call the drug-of-the-month phenomenon, where we focus on crack this month, heroin last month, PCP the month before. I believe strongly that we will not overcome addiction in this Nation attacking it one drug at a time. I believe that it is important that we develop an over-arching strategy to address addiction of many types.

If there is one issue I can speak to for the entire professional field, it is that we should not separate out alcohol from other drug abuse in the treatment context. We believe strongly that the basic dynamics of addiction are the same regardless of what psychoactive substance is being used or abused.

In addition we must remember that the kids who are easiest to prevent from using drugs have already been dissuaded. Those who are easiest to treat in many respects have been helped. To a very

real extent, we are now faced with the hardest cases to cope with in this country.

I feel this is an important point because we are often embarked on a task now of habilitation not rehabilitation, and that will be a much more expensive and formidable endeavor.

There are three major and very quick policy recommendations I would like to make as we attempt to develop our Nation's strategy on the war on drugs.

The first and the most important is to identify and intervene in an addict's life early in the degenerative spiral of addiction. Drug addiction is no different than any other illness—the later we treat it, the lower prognosis we will have for a successful outcome. Efforts to this end should include the development of what I call client assistance programs. These programs should be placed in virtually every Federally-supported job training, housing or welfare program in this country, and would include a number of major components.

First, an agency policy regarding alcohol and drug abuse; the availability of alcohol and drug abuse assessment and referral protocols, so we can diagnose and intervene earlier; alcohol and drug education and prevention program; onsite aftercare support services. We should also fund employee assistance programs for two high-risk groups that are currently largely underserved by our Nation's employee assistance efforts.

The first one is employees of minimum wage jobs, and the second is employees of nonprofit organizations, which represent, I understand, the fastest-growing component of our economy.

The minority population of both groups is higher than that of the general work force, and the age of each is lower. These facts alone create compelling reasons for the developing services targeted toward these groups.

Many employees in minimum wage jobs have dropped out of school and are semi-literate and unskilled, often coming from fragmented families. If they show a degree of motivation to seek a job, they are what I call high-risk motivated youth. This is just the group that should receive significant attention from our Nation's efforts to address drug abuse.

Employees in the Nation's nonprofits are often high-risk and disproportionately come from the client populations they serve. Many nonprofit organizations appropriately see it as part of their mission to hire these individuals. It is not uncommon for a former AFDC recipient to be working with current welfare recipients, or a recovering drug addict to be working with current ones. Such workplaces would provide excellent spots for employee assistance programs.

Finally, in look at this issue we must understand that the major catalyst for intervention in white America is the economic cost of drug abuse on a family. In a stereotypic sense, a father develops a drug habit as a result of family finances falling apart. This reality is then used to intervene in Dad's addiction, and he is persuaded to seek treatment. In the black community, tragically, the opposite often takes place: A man is involved in drugs; he is bringing financial resources to the family. In white America, there is a financial

motivation for intervention in drug abuse; in black America, tragically, often there is a financial deterrent.

The development of client assistance and employee assistance programs in the Nation's nonprofits will enable us to reach large number of high-risk individuals before their drug problems reach a point where they run afoul of the law.

We must further understand that for whites there are four major access points to treatment in this country: family members, friends, employers and schools. For blacks, the major access point is the court system. This is of significant importance because the two major predictors of who will be successful in treatment are does the client have a job, and is the family involved in the recovery process.

If you access treatment via the court system, you are less likely to have either.

A second and quick policy recommendation of mine is the development of comprehensive outpatient aftercare support systems. We spend billions of dollars in this Nation getting people off of drugs and pennies keeping them off. In my home country of Hennepin County, 5 percent of the clients consume 30 percent of the resources, and that percentage is growing each year. This is a major public policy mistake.

I feel that the key to long-term quality recovery from addiction is involvement in developing a structured outpatient aftercare support system. This would include psychological counseling, job training, nutritional and dietary information which is often overlooked and not only serves as an environmental catalyst for addiction but also for relapse; family counseling and drug-free social activities.

I feel that recovery from addiction is a cultural process; it is not a clinical event.

My third policy recommendation is the development of what I call postprevention and pretreatment services. Mark Twain once said, "If the only tool you have is a hammer, everything looks like a nail." Often the only tool we have is school-based prevention, so we feel everyone needs it. The reality is there is a large group of kids who are marginal episodic users and abusers of drugs. They need more than a curriculum in health class but less than an expensive treatment program. Such a program should be school- and/or community-based and would include both didactic and clinical components. Participants in such a program would be likely to be one of the 30 million Americans under the age of 20 who have a drug addict or an alcoholic for a parent.

The issue of children of alcoholics, or COA's, is an important and overlooked problem in this Nation.

Further, I feel it is a mistake to have all of our prevention strategies school-based. As was mentioned earlier, in many respects the kids who need the help the most aren't in school.

In addition, the highest-risk kids can't learn civics, math or history taught by traditional teaching methods. Whatever would make us think that they can learn prevention taught the same way? At a minimum, we should reconfigure our prevention curriculum based on different learning styles.

In addition, we should develop community-based prevention strategies. The President's proposed drug corps is a positive step in this direction.

We must expand prevention strategies that are targeted toward ameliorating the most destructive aspects of drug abuse. A central theme of this effort is to address issues and problems that are winnable—closing crack houses, removing gang graffiti from local buildings, assisting landlords in identifying and evicting drug users and sellers, creating local drug-free zones with the assistance of police, prosecutors, landlords and the like. Many of these activities have been undertaken by organizations like 100 Black Men, the Nation of Islam, and my organization.

Finally, we face a number of dilemmas regarding addiction in the black community. One subtle but important issue is the reality that black people, I believe, have a higher tolerance for emotional pain. This helps us survive in a hostile world but it also creates us to tolerate more dysfunctional behavior from one another. This is a major dilemma in my community and causes us to seek treatment much later in the degenerative process of addiction.

Another issue is the drug/crime cycle in black America. In white America, a kid often starts smoking cigarettes, then drinking, then using drugs, and finally commits crimes to support his habit. In black America, the opposite often is the case. A kid is often attracted to a deviant criminal hustling lifestyle as a prelude to his drug use. He tragically starts selling drugs often before he starts using them.

Perhaps the most serious dilemma we face is the effort to acknowledge the disproportionate impact that addiction has on the black community without contributing to the stigmentation of my community. Many of us fear that as the public perceives addiction as being primarily a black and Hispanic phenomenon, the war on drugs will stop or shift even more to a law enforcement response.

Thank you very much.

[The prepared statement of Mr. Bell follows:]

PREPARED STATEMENT OF PETER BELL

In addressing drug abuse in this country, we must resist the temptation to focus on what I call the drug-of-the-month phenomenon, where we focus on crack this month, heroin last month, PCP next month, etc. We will not overcome addiction in this nation attacking one drug at a time. The basic dynamics of addiction are the same regardless of what substance is being used. In addition, we must remember that the kids who are easiest to prevent from using drugs have in many cases already been dissuaded. Those who were easiest to treat have already been helped. To a very real extent, we are now faced with the hardest drug problems to cope with.

There are three major recommendations I would make as we attempt to develop our nation's strategy for its war on drugs.

The first and perhaps most important issue is to identify and intervene in an addict's life early in the degenerative spiral of addiction. Drug addiction is no different than any other illness - the later we treat it the lower the prognosis for success we will have. Efforts to this end might include the development of what I call client assistance programs. These programs would be placed in virtually every federally supported job training, housing or welfare program in the country and would include the following components.

A. An agency policy regarding client chemical use and abuse;

B. the availability of alcohol/drug assessment & referral;

C. alcohol/drug education/prevention programs;

D. on-site aftercare support groups;

E. well developed employee assistance programs (EAP's) for staff.

Coupled with the development of C.A.P.'s we should also fund employee assistance programs for two high risk groups that are currently largely unserved by the nation's employee assistance efforts: 1) employees in minimum wage jobs; 2) employees of non-profit organizations. The minority population of both groups is higher than that of the general workforce and the age of each group tends to be lower. These facts alone create a compelling reason for developing services targeted toward these groups. I would also suggest that each of these groups of employees tends to be higher risk. Many employees of minimum wage jobs have dropped out of school or are semi-literate and unskilled, often coming from fragmented families. Yet they show a degree of motivation to seek a job. They are what I call high-risk, motivated youth. This is just the group that should receive significant attention in our national effort to address drug abuse.

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The development of client assistance programs in the nation's non-profits would enable us to reach large numbers of high risk individuals before their drug problems reach a point where they run afoul of the law.

We must understand that in white America, there are four access points to treatment: family members, friends, employers and schools. For blacks, the major access point is the court system. This is of significant importance because the two major predictors of who will be successful in treatment are: 1) Does the client have a job? and, 2) Is the client's family involved in the recovery process? If you access treatment via the court system you are less likely to have either.

My second policy recommendation is that we develop a comprehensive outpatient aftercare support system. We spend billions in this nation getting people off drugs and pennies keeping them off. This is a major public policy mistake. I feel the key to long term quality recovery from addiction is involvement in a structured aftercare program that would include:

A. Psychological counseling;
B. job training & basic skill development;
C. nutritional and dieting information;
D. family counseling;
E. drug/alcohol-free social activities

My third policy recommendation is the development of what I call post prevention and pre treatment programs. Mark Twain once said, if the only tool you have is a hammer, everything looks like a nail. Often the only tool we have is school based prevention so we feel everyone needs it. The reality is there is a large group of kids who are marginal episodic users of drugs. They need more than a curriculum in health class, but less than an expensive treatment program. Such a program should be school and community-based and include both didactic and clinical components. Participants in such a program wold likely be some of the thirty million Americans under the age of 20 who have a drug addict or alcoholic for a parent. The issue of children of alcoholics is an important and overlooked problem in this country. Further, I feel it is a mistake, to have all our prevention strategies school based. In many respects the kids who need the help the most, aren't in school. In addition, the highest-risk kids can't learn civics, math or history taught by traditional teaching methods. Why would we think they can learn prevention taught by the same methods? At a minimum, we should re-configure our prevention curriculum based on different learning styles. In addition, we should develop community

based prevention strategies. The President's proposed drug corps is a positive step in this direction.

We must expand prevention strategies that are targeted toward ameliorating the most destructive aspects of drug abuse. A central theme of these efforts is to address issues and problems that are winnable; i.e., closing a crack house; removing gang graffiti from local buildings; assisting landlords in identifying and evicting drug users and sellers; creating local drug free zones with the assistance of police, prosecutors, landlords, treatment providers, etc. Many of the above mentioned activities have been undertaken by groups like "100 Black Men," the Nation of Islam and my organization.

Finally, we face a number of dilemmas regarding addiction in the black community. One subtle, but important issue in the black community is the reality that black people have a higher tolerance for emotional pain. This helps us survive in a hostile world but it also causes us to tolerate more dysfunctional behavior from one another, which in turn causes us to seek any treatment later and makes it less successful.

Another issue is the crime/drug cycle in black America versus white America. In white America a kid often starts smoking cigarettes, then drinking, then using drugs and finally commits crimes to support his habit. In black America, the opposite is often the case. A kid will be attracted to a deviant criminal hustling lifestyle as a prelude to his drug use. He will start selling drugs often before he starts using them.

Perhaps the most serious dilemma we face is the effort to acknowledge the disproportionate impact that addiction has on the black community without contributing to the stigma of that community. Many of us fear that as the public perceives addiction as being a primarily black and Hispanic phenomenon, the war on drugs will stop or shift even more to a law enforcement response.

The CHAIRMAN. Thank you for that very powerful testimony. You raised many important points. We have tried to build the aftercare services you mentioned into our legislation. We had amendments on the drug bill, and we tried to deal with this need, and hopefully you will come back in several months and give us some indication as to how that aspect of it is working.

We talked very briefly with Dr. Schuster before about the trained professionals. We have also included that as one of our priorities. Could you elaborate a little about this, what the needs are in this area?

Mr. BELL. I think there is a strong need for increased personnel in this field through the entire continuum of services—prevention, diagnosis, treatment, research and the like. Many of our colleges and universities I think are inadequate to provide this type of training. As you are well aware, Senator, many people find their way into this field as a result of their own experience, and I think that can be one important credential, but it really doesn't give an individual the depth or breadth that he or she needs.

Clearly, increased efforts are needed to have more trained professionals come into this field and have it be a profession, and oftentimes that is not the case.

The CHAIRMAN. I am wondering if my colleagues would agree if we might hear from Pete Shrader and then come back to Mr. Bell.

Pete Shrader is from Alexandria, VA. He had a serious drug abuse problem and dropped out of school as a result. He has completed a program of residential treatment for drug abuse and is now back in school and holding a job. He has generously agreed to share his experience with the committee, and he is accompanied today by his mother, Connie Pulliam.

I want to welcome both of you here. Maybe we could go over the story with you, Pete, if that's all right, and then we'll come back and ask both you and Mr. Bell some questions about how you view some of these issues. So if that's OK, we'll proceed in that way.

I just have some questions to run through regarding your story, if that is comfortable. I'll ask you some questions, and you just feel free to respond in whatever way you would. Is that OK?

Mr. SHRADER. Yes, that's OK.

The CHAIRMAN. We're glad to have you, and we welcome your mother here.

Could you tell us how old you are?

Mr. SHRADER. I'm 18.

The CHAIRMAN. And you are a senior at T.C. Williams High School in Alexandria; is that right?

Mr. SHRADER. Yes.

The CHAIRMAN. And you'll graduate next June.

Mr. SHRADER. Yes.

The CHAIRMAN. Do you have a part-time job?

Mr. SHRADER. Yes, I do.

The CHAIRMAN. And what do you intend to do after your graduate?

Mr. SHRADER. I am going to join the Air Force.

The CHAIRMAN. When you were 15 years old, did you start drinking?

Mr. SHRADER. Yes, I did.

The CHAIRMAN. And what did you drink?

Mr. SHRADER. Alcohol, liquor and beer.

The CHAIRMAN. And did you start smoking marijuana at about that time?

Mr. SHRADER. Yes, I did shortly after that.

The CHAIRMAN. And how often did you do that?

Mr. SHRADER. I was doing that I'd say about three times a week when I first started, and then it just went on and on to daily use.

The CHAIRMAN. And how much would you smoke in daily use?

Mr. SHRADER. About a $10 bag worth.

The CHAIRMAN. In layman's terms, how many joints is that?

Mr. SHRADER. That's about five or six.

The CHAIRMAN. And then I understand you began using PCP; is that right?

Mr. SHRADER. Yes, it is.

The CHAIRMAN. Why did you do that?

Mr. SHRADER. Well, after I smoked so much marijuana, it didn't have an effect on me like it did when I first started, so then I tried PCP, and that had a stronger effect on me.

The CHAIRMAN. What kind of effects did it have on you?

Mr. SHRADER. It made me hallucinate a lot and feel a lot different; it just made me feel better.

The CHAIRMAN. Were you also selling the PCP to help support your habit?

Mr. SHRADER. Yes, I was.

The CHAIRMAN. And did you stop going to school?

Mr. SHRADER. Yes; in the end part of it, yes, I did.

The CHAIRMAN. And was your mother very upset?

Mr. SHRADER. Yes, she was.

The CHAIRMAN. We'll come back to that.

In the summer of 1987, did she persuade you to talk to Mrs. Katzer, a social worker, to get help?

Mr. SHRADER. Yes, she did.

The CHAIRMAN. And were you going to summer school at that time to try and make up some of the work you had missed?

Mr. SHRADER. Yes, I was.

The CHAIRMAN. So you met Mrs. Katzer, but you just were not ready to give up drugs; is that right?

Mr. SHRADER. That's correct.

The CHAIRMAN. And you continued on the PCP for another year.

Mr. SHRADER. Right.

The CHAIRMAN. And did the amount increase?

Mr. SHRADER. Yes.

The CHAIRMAN. What was it doing to you during this time?

Mr. SHRADER. At this time, I was just doing a lot of things that I hadn't been doing at first and it had just gotten to the point where it made me think I didn't care about anything; and I gave up on myself and didn't care about myself. I was just basically doing a lot of things that I wasn't doing at first.

The CHAIRMAN. Did you finally decide in the summer of 1988 that you were ready to do whatever it took to get off the drugs?

Mr. SHRADER. Yes, I did.

The CHAIRMAN. And why did you decide that?

Mr. SHRADER. Well, I didn't have any goals except for myself, and my life just seemed like it went down the drain, and I was really getting sick of doing what I was doing, and a lot of other people were sick of what I was doing and were fed up. So it came to the point where I knew that I had a problem, but I didn't really know how to ask for help.

And it really made me feel comfortable when my mother came to me and talked to me about it, because I didn't feel like I could go to her and tell her I had a drug problem. So she made me feel real comfortable about it, and we talked, and I decided on my own that I did need help and I was willing to go into treatment then.

The CHAIRMAN. Well, that is certainly a real tribute to your mother.

Did you at some time, then, see Mrs. Katzer, and did she arrange for you to go to Second Genesis?

Mr. SHRADER. Yes, she did.

The CHAIRMAN. And was that voluntary on your part?

Mr. SHRADER. Yes, it was.

The CHAIRMAN. And how long were you there?

Mr. SHRADER. I was there for a year.

The CHAIRMAN. And have you had any PCP or other drugs since you went to Second Genesis?

Mr. SHRADER. No, I haven't.

The CHAIRMAN. And how did they help you get along without the drugs?

Mr. SHRADER. Basically, they teach you how to deal with your feelings and to talk about things, and how you don't have to react to things that bother you and that you couldn't talk about and run away from. There were a lot of things I would run away from when I was involved in drugs, and this program taught me how to face it and that it wouldn't hurt me any worse to talk about it than to try to hide it and fight it, but just to give up and talk about it and work things out, and it would be much better this way.

The CHAIRMAN. Did you go back to Second Genesis every week for 3 months for followup counseling?

Mr. SHRADER. Yes, I did.

The CHAIRMAN. And did you graduate then from Second Genesis?

Mr. SHRADER. Yes, I did.

The CHAIRMAN. And I understand that you had known two of the young people with you before you were at Second Genesis; is that right?

Mr. SHRADER. Right.

The CHAIRMAN. And what has happened to them?

Mr. SHRADER. One, a female, is married and expecting a baby; the other one is in jail facing 2 years.

The CHAIRMAN. So now you are back in high school in your senior year. Do you feel lucky to be there and doing well?

Mr. SHRADER. Yes, I do.

The CHAIRMAN. And what do you think you'd be doing now if you had not gone to Second Genesis?

Mr. SHRADER. I think I would either be dead or I'd be locked up.

The CHAIRMAN. What has happened to the other young people who were using PCP with you?

Mr. SHRADER. A lot of them are locked up now, or they are still out on the street, getting high, selling it, and things like that.

The CHAIRMAN. What advice do you have for young people who are being exposed to drugs?

Mr. SHRADER. Just that it's not really worth it. It was real curious to me when I was young, and I wanted to try it. But it's really not worth trying it. It's best just to get with positive people who are trying to do something with their lives, because that kind of lifestyle really isn't worth it.

The CHAIRMAN. Well, Mrs. Pulliam, you must be very proud of your son.

Mrs. PULLIAM. Yes.

The CHAIRMAN. Do you think he could have stopped using the PCP without the help he received certainly from you and Mrs. Katzer and Second Genesis?

Mrs. PULLIAM. No, I don't think he could have stopped.

The CHAIRMAN. Do you have any advice for mothers of young people such as your son?

Mrs. PULLIAM. Well, the only thing I could say is that I always felt that if one of my children were on drugs, I would know right away, but I found that not to be so. He was on for quite a while before I found out that he was. It had gotten to the point where when I knew, he wasn't getting up and going to school, he was avoiding us totally.

So you can't always say that you would know, because you might not know until they have really been on for a while. And then the best thing to do is—at first, I was very angry and did show my anger—but the best thing to do is just to sit down and say, "Let's talk about it and see what we can do about it," and really try to let them know you love them, you don't want this for them, and try to let them see that this isn't the right thing for them to do, and go from there to try to get help.

The CHAIRMAN. Well, Pete, I want to thank you for coming and sharing this story. You've got a lot to be proud of, and I think your story will be an inspiration for many other people. So, very well-done, and congratulations to you.

Mr. SHRADER. Thank you.

The CHAIRMAN. I'll come back to some questions for Mr. Bell, but I'll recognize Senator Durenberger.

Senator DURENBERGER. It has gone through my mind as I listened to Pete talk, that maybe Peter, could you ask him a couple of questions about his aftercare program? I know how strongly you feel about this program and about the resources that are available.

Would that be inappropriate to ask you to do that so we could explore that issue a little bit and give us some idea of——

Mr. BELL. No, I think that's fine.

One of the biases that I think I have and many people in the field have—and Pete, let me ask you this question—is around the issue of not only learning how to deal with your feelings and the like, but learning how to play again, you know, without the use of drugs, learning how to have fun and to socialize again. I think the question I would ask is was that a difficult task, and how have you done that?

Mr. SHRADER. It was very difficult, being out there and knowing all the negative people, and when you come back you don't really know them. But I had a few people that I knew, and when I was in treatment they told me it would be hard for me. But I just got in my mind that I knew what I was trying to do, so when I came out, I didn't have too many friends but I had a few friends that were in treatment that had gotten out, so I would go and visit them, and I would also go to NA meetings, and I met a lot of people through there and a lot of events that happened in there. And I also used to go back to the place where—and I still do—the place where I came from, Second Genesis. I go and visit there a lot and talk to the counselors and hangout with the people in there when they come home.

Mr. BELL. You know, there is a lot of discussion around can a drug addict ever learn how to drink again or use any other chemicals responsibly. What are your feelings on that; do you think you can?

Mr. SHRADER. I feel like I can't drink, I can't do anything again, because once I drink, I am going to drink to get drunk, and once I get drunk, I'm going to want that feeling again of that PCP, and that's probably what I'll do.

Mr. BELL. Thank you.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Let me just ask, following that, how available are PCP and these drugs in the school now—or, let's not say in your school; let's just say how difficult is it for young people to get them?

Mr. SHRADER. I don't think it is too hard for them to get it because you can always tell who has it—the person who has on all the gold chains and all the flashy stuff—you know they're the ones who know about it. So if they really want it, I don't think it's hard for them to get it. But personally, I couldn't tell you who to get it from, because I don't look for them.

The CHAIRMAN. Good. Senator Simon.

Senator SIMON. We're not asking for names and addresses here.

I just want to say to Pete and his mother we are very proud of you. Is your counselor here, by any chance, who advised you?

Mr. SHRADER. Yes.

Senator SIMON. Right over here—well, you are one of the heroines in this story, too.

The CHAIRMAN. Is this Mrs. Katzer?

Mrs. KATZER. Yes, Senator.

The CHAIRMAN. Well, we want to recognize you. Congratulations.

Senator SIMON. We appreciate what you have done.

Mrs. KATZER. Thank you.

Senator SIMON. Dr. Bell, what you say about follow-through strikes me——

Mr. BELL. Let me clarify something—I am not a doctor. My mother thanks you, but I am not.

Senator SIMON. All right, but we'll give you an honorary "doctor" here.

Mr. BELL. OK.

Senator DURENBERGER. We really ought to.

Senator SIMON. What is your background, may I ask, prior to becoming executive director of your group?

Mr. BELL. I got an undergraduate degree in social service program administration, but I got that after I started my institute. Shortly after my recovery, as Senator Durenberger indicated, I did a research project for the State of Minnesota to really assess the efficacy of alcohol and drug abuse services in terms of the black community. Based upon that research project, I wrote a grant and founded my institute.

Senator SIMON. And that is only for Minnesota?

Mr. BELL. No. About half of our efforts go outside of the State of Minnesota. We do a great deal of training, develop videos, publications and the like. But it is really focused on the issues of alcohol and drug abuse as it impacts the Nation's black community.

Senator SIMON. When you talk about the need for follow-through and that we are spending pennies there while we spend dollars in other areas, instinctively, I think you are right. How do we make sure we get this follow-through? Is there anything the Federal Government can do to——

The CHAIRMAN. You voted for it, Senator.

Senator SIMON. And if I may ask the Chairman here, what do we have in terms of follow-through in our legislation?

The CHAIRMAN. Well, we tried to build into the system evaluation, but quite frankly, we had some differences with the Administration about having guidelines by the Secretary to issue guidelines to the States in each of these areas, because the Administration would not support that particular position.

But we did work out in the compromise that they were going to effectively issue—not regulations—they were guidelines. They resisted "regulations", but we did settle for "guidelines". So we are going to monitor that very closely, but I think all we can do in that area is work with the Administration in the development of those guidelines, and we would like to ask Mr. Bell to help us as they begin to develop those guidelines so we can be effective.

Mr. BELL. There is a very important point about aftercare that I want to interject very quickly. Oftentimes the continuum of care is education, then prevention, then diagnosis as a third component, then treatment, and then aftercare. Oftentimes if a person fails in treatment, they do not necessarily need to go back to treatment again. Oftentimes, reinvolvement with the aftercare program is all they need. That is much more cost-effective than having them start at the beginning of the line, going through a whole treatment regimen from the beginning. That is an additional benefit of having a comprehensive aftercare service in this Nation.

Senator SIMON. Let me just say I thought your statement was an eloquent one, and to the extent that you can help provide leadership not just in Minnesota but in the Nation I think is a significant contribution, and I appreciate it.

I want to thank all three witnesses this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Cochran.

Senator COCHRAN. Mr. Chairman, just let me thank the witnesses for being here to give us this perspective of the problem that we are trying to deal with. And I congratulate you, Mr. Chairman,

on continuing to pursue this issue through hearings and attracting a wide range of information to the committee for our review and consideration.

Thank you very much.

The CHAIRMAN. Thank you, Senator Cochran.

I noticed in your testimony, Mr. Bell, you mentioned not treating one drug at a time. But is there something more that we ought to be focused on with regard to crack than the others, or how do you fit that comment into it?

Mr. BELL. I think crack is a more highly-addictive drug. I think the degenerative process of addiction is accelerated more with crack than with other drugs. The analogy I make is to a video that is on fast-forward—you see each frame, but it is going quicker. But I think the basic dynamics of addiction are the same. If you interview most addicts in this country, they are polydrug abusers. They have preferences for crack or heroin or PCP or alcohol, but in the absence of those chemicals they are using a whole host of substances in concert with one another. And the professionals in the field thing it is nonsensical to attempt to divide those out. We set up nice bureaucratic lines, but our clients do not respect those and do not adhere to those.

The vast majority of addicts and alcoholics are polydrug abusers, and we need to treat their addiction to all of the substances. And that is the most difficult issue we have in convincing the Federal Government today is of that fact. There is a need to separate them out, and the field would be in strong opposition to that.

The CHAIRMAN. OK. Senator Durenberger touched a little bit on the insurance aspects of it and how we are really going to come to grips with it, and another time I hope we will be able to get a chance to get into some of your ideas in that areas. Maybe I'll give you a quick opportunity here.

Mr. BELL. The only thing I would say about insurance is that I think—and this may surprise you—that it was a strategic public policy mistake to wed reimbursement for treatment as close as we have to insurance because the people who need the most expensive, long-term, costly care are the very individuals unemployed and unable to pay for it. It is an insidious, inverse correlation that only exists for this illness and does not exist for any other.

The people who are coming into the system now are more in need of long-term, structured care. They don't have a job; therefore they can't pay for their treatment. That is also why aftercare has been underdeveloped in this country, because the insurance companies have been resistant to pay for it. It is hard to quantify aftercare; therefore they can't price it, therefore they don't provide it; as a result, by and large, it is not provided.

Senator DURENBERGER. Mr. Chairman, would you yield to me on this point?

The CHAIRMAN. Yes.

Senator DURENBERGER. One of the situations in which the Chairman and I both find ourselves in now is a group called the Pepper Commission. And one of the issues that the Chairman hasn't addressed in this commission—because he has been so busy addressing it here—is the fact that if this country is going to at some time in the future provide universal health coverage for all Americans. I

think what you are proving today is that this problem of access to health care, regardless of how you want to define it, you'd better define it in the broadest possible terms in terms of not just going to see the doctor, but in the way that Pete Shrader has described it and his mom has described it and the young lady over here—to include a broad range of coverage.

And I would say to you, Mr. Chairman, I think it is very difficult for us sitting on that Pepper Commission to say we're going to come up with an answer to universal access to health care in this country unless we are able to send a message to the American people that that includes the kind of definition of health care coverage that is as broad as that faced by moms and dads like us, who don't recognize a health problem when it is right in front of us because the kid is still going away to school, we don't know what he does when he is there.

I think this is an enormous need that this country needs to deal with, and I think we really are going to have to deal with it in some way also within the context of universal health care.

The CHAIRMAN. I think there is a lot to that.

Now, a lot of what has been talked about here in the areas of prevention and education, involves community activities in a significant way. You are mentioning getting early identification of those who really have the potential and involving the community and having community-based systems which provide areas of support, the mentoring which is so important, the jobs which are so important, outside of the question of having a decent home or food to eat.

I think we that is certainly an aspect of this as well. We sure as the devil can't legislate all of that, but I think hopefully what we can do is demonstrate where some of these are really working well and to try and find out what those ingredients are and try to see if we can't replicate those in important ways.

I interrupted Senator Simon.

Senator SIMON. Just one final question, Mr. Chairman.

You just said, Mr. Bell, increasingly the unemployed are those who need help. I asked Dr. Schuster this question on the basis of his statistics. If we move on the problems of the pockets of unemployment in this country, are we going to reduce the abuse problems?

Mr. BELL. I think without question, we will. Certainly there is a correlation between unemployment and addiction. But as you indicated, correlation doesn't mean causation. So we still are wrestling with the chicken-or-egg question. I think not only will it reduce the incidence and prevalence of addiction; it will make our recovery programs more effective.

Senator SIMON. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. OK. We are delighted to have you both here. Thanks an awful lot.

Mr. SHRADER. Thank you.

The CHAIRMAN. Our next panel includes Dr. Des Jarlais and the Reverend Reginald Williams. Don Des Jarlais is a distinguished drug treatment professional and researcher, currently director for AIDS Research and Evaluation in a New York State substance abuse agency, the Narcotics and Drugs Research, Inc. He will share

his thoughts about the intersection of drug abuse and the AIDS epidemic.

Dr. Des Jarlais, we are delighted to have you back.

**STATEMENTS OF DR. DON DES JARLAIS, DIRECTOR FOR AIDS RESEARCH AND EVALUATION, NARCOTICS AND DRUGS RESEARCH, INC., NEW YORK, NY AND REVEREND REGINALD WILLIAMS, DEPUTY DIRECTOR, ADDICTS REHABILITATION CENTER, NEW YORK, NY**

Dr. DES JARLAIS. Thank you, Senator.

I have submitted a written statement, so I would like to just fairly briefly touch some of the highlights of it.

We are now at a very unusual historical situation where we are proposing a largescale expansion of our drug abuse treatment system. There is the possibility that this largescale expansion of our treatment system may fail. If so, it will probably be decades before we would ever try again.

The AIDS epidemic is dramatically changing drug abuse treatment programming in this country. This is most often seen in the northeastern United States, where perhaps 30 to 40 to maybe even 50 percent of IV-drug users coming into treatment are already infected with HIV.

It is also seen with people who not only inject drugs, but people who smoke crack. Two recent studies in New York showed between 20 and 30 percent of crack users coming in to sexually-transmitted disease clinics were already infected with HIV.

Crack use in itself does not spread the virus, but crack use is often associated with unsafe sexual activity. For males, the use of crack often leads to increases in sexual activity—in fact, in many places, crack is marketed as an aphrodisiac, and people out on the streets selling crack say that crack itself will make you feel good, but it will make sex feel even better. For women, many of them will exchange sexual services in order to obtain crack.

While the HIV and drug problem is currently concentrated in the Northeast, there is a potential for very, very rapid spread of the virus particularly among people who inject drugs.

In New York City, the HIV-infection rate went from about 10 percent to 40 percent in 3 years; in Bangkok, it went from about 2 percent to 40 percent in about 24 months; in Edinburgh, it went from essential zero percent introduction of the virus to about 50 percent among drug injectors in a period of a little over 2 years. So even areas of the country like the West Coast or the Midwest, where there is comparatively little HIV infection, face the potential for rapid spread of the virus.

HIV infection causes great additional burdens for our drug abuse treatment programs. Part of it is financial, simply providing treatment for HIV-related diseases. We would estimate that just treating HIV-related disease using aerosolized pentamidine, providing AZT, could add $10,000-$12,000 additional cost to drug abuse treatment for a person infected with HIV.

More importantly, HIV causes stress and psychological burdens for the drug abuse treatment staff. With HIV, we now have to worry about people who are in our drug treatment programs and

drying; they are dying a slow and protracted death, often in considerable physical pain. As they die, they worry that they may have spread the virus to their sexual partners, to their children.

Drug professionals, who are not particularly well-trained to begin with, have had really essentially no training dealing with these complex issues of how to work with someone who is dying, and they particularly face difficulties with the idea that some of the staff who are ex-addicts may also be HIV-infected and developing AIDS, and the threat that AIDS poses to the rehabilitation process—that someone may have successfully beaten their drug problem, and 2 or 3 years later they start to develop AIDS disease.

In addition to the problems around death and dying, there are very difficult issues counseling people in how to remain alive with the threat of HIV. In part this involves sexual counseling, trying to encourage safe sex among drug users so that people who are carrying the virus do not spread it to their spouses. It involves counseling around birth control and trying to prevent transmission to newborn children. These can be very, very difficult counseling issues. Many drug users say that, yes, they are willing to practice safe sex, to use condoms, but they are afraid that their spouse or their boyfriend or girlfriend will leave them if they start practicing safe sex.

Many women who are HIV-positive want to have children. They want to leave a child because they know that they might not live much longer. There is a substantial probability that that child will be infected with HIV, and the child will die also.

So these counseling problems are tremendously difficult. They are not something that you can do very easily. They create tremendous psychological burdens and stress for the staff of drug treatment programs.

One final issue is the problem of HIV has dramatically increased our concern about relapse among people who go through drug treatment programs. Relapse is a very common problem. It occurs in maybe three-quarters of people who go through drug abuse treatment programs. But at least prior to AIDS, it was not a fatal problem; people could have relapses and go back to treatment with a long-term potential for becoming and remaining free from illicit drugs. Now that there is the potential that for someone who injects drugs, a single relapse may involve infection with HIV if they are sharing drug injection equipment, for a crack user, a relapse may involve high degrees of unsafe sexual activity and exposure to HIV. So that we are now having to worry about the relapse problem and having to try to anticipate it and teach drug users that if they do relapse, it is very important not to share drug injection equipment, it is very important to avoid unsafe sex.

Working with this idea of a relapse being very likely involves a radical change in the mindsets of most drug abuse treatment program staff who don't really know how to plan for relapse, who do not know how to talk about what happens if relapse occurs and making sure that HIV infection doesn't occur during relapse without seeming to tell their client that relapse is inevitable and to undermine the optimism needed to go through drug abuse treatment. It is not that drug treatment staff find this a totally impossible task to teach about safer injection or teach about safer sex, but it is

requiring a dramatic reevaluation of what they are doing in treatment and how they can emphasize long-term success, long-term abstinence from illicit drugs, while knowing that a relapse is statistically very, very likely.

To summarize, the AIDS epidemic is creating new and totally unexpected stresses on our drug abuse treatment programs, both financial and psychological stress on the staff. This poses the real potential that many new funded treatment programs could fail. We would see this fairly clearly in terms of HIV infection among people who came into treatment or who relapsed from treatment. We could also see it very easily in terms of staff burnout and demoralization. So that as we move forward in planning how we will spend the new money that Congress is appropriating, it will be very important to look at the AIDS issue. Clearly, areas of the country where AIDS is already a massive problem are going to require additional resources.

We will also need to set up some sort of monitoring and evaluation effort so that programs that are doing well with the AIDS issue can be replicated in other areas, and programs that are not doing well can be provided with technical assistance.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Des Jarlais follows:]

## PREPARED STATEMENT OF DON C. DES JARLAIS, PH.D.

October 25, 1989

Mr. Chairman, Honorable Senators. I would first like to thank the committee for this opportunity to testify before the committee. As a nation, we are on the verge of a large scale expansion of our system for drug abuse treatment, perhaps an expansion large enough to meet the actual needs for drug abuse treatment in the country. It is of utmost importance that we properly manage such an expansion of the treatment system. If we do not properly manage such an expansion, it may be decades before there again is sufficient political commitment to try providing drug abuse treatment for all of those who need it.

The recent trends in illicit drug use in the United States, particularly for cocaine, clearly show declines in non-regular ("casual") drug use and increases in intensive drug use (addiction). While actions to discourage casual use of illicit drugs

can be justified, it will be our ability to deal with intensive drug use that primarily determines the success of our demand reduction efforts in the country.

One important consideration that must be kept in mind for any planned expansion of our drug abuse treatment system is the effect of the AIDS epidemic on drug abuse treatment. The AIDS epidemic has fundamentally changed the nature of drug abuse treatment. This can most easily be seen in our programs for persons who inject illicit drugs and in the Northeast, where many intravenous drug users are already infected with the human immunodeficiency virus. The effects of the AIDS epidemic will also apply to programs for persons who use drugs, like crack cocaine, that are associated with unsafe sexual activity, and to other areas of the country, where HIV is currently spreading among drug users.

1. The current size of the problem of HIV infection among intravenous drug users. Our best estimates indicate that there are somewhere over one million persons in the United States who inject illicit drugs, and that between twenty and thirty per cent of these are already infected with HIV. There is great geographic variation in the HIV infection rates among intravenous drug users. In the New York area, between forty and fifty per cent of intravenous drug users recently entering drug abuse treatment programs are already infected with HIV. In other cities on the east coast, such as Boston, Baltimore and Miami, the infection rates range between fifteen and thirty per cent. Large cities in the midwest, such as Chicago and Detroit, also have infection rates between twenty and thirty per cent. Cities on the west coast generally have lower HIV infection rates among intravenous drug users, with San Francisco at approximately fifteen per cent and Los Angeles and Seattle at ten per cent or less.

2. Potential for rapid increases in HIV among drug users. Cities that currently have low HIV infection rates among drug users need to realize that the virus can spread very

rapidly among persons who inject illicit drugs. There are many examples of areas where the HIV infection rate among intravenous drug users has gone from approximately ten per cent to approximately forty per cent in two to three years. This occurred in New York City, Edinburgh, Scotland and Bangkok, Thailand.

There is also the potential for spread of HIV through unsafe sexual activity associated with the use of many drugs, particularly crack cocaine. Two recent studies of persons attending sexually transmitted disease clinics in New York City found twenty and thirty per cent of the crack users to be infected with HIV. While the spread of HIV through drug related sexual activity with undoubtedly be slower than the spread through the sharing of drug injection equipment, the number of persons at risk for HIV infection because of unsafe sexual activity related to drug use is undoubtedly much higher than the number of persons at risk through the sharing of drug injection equipment.

3. Additional costs of HIV infection for drug abuse treatment programs--financial. The AIDS epidemic is greatly increasing many "costs" of providing drug abuse treatment. The easiest to measure of these costs are the financial ones. There are many practical reasons for integrating HIV treatment into drug treatment programs. This can, however, dramatically increase the costs of providing drug abuse treatment. The current costs of AZT for an HIV infected person range from approximately $3500 per year to $8000 per year, depending upon whether the person is asymptomatic or has developed AIDS symptoms. Aerosolized pentamidine can add another $1500 per year in medication costs. If one then adds the costs of medical testing and the medical staff to administer this treatment, the additional costs for an HIV infected drug abuser could be around $10,000 per year in addition to the $3000 to $12,000 per year for basic drug abuse treatment. Here it is worth noting that there are probably 200,000 to 300,000 drug abusers in the U.S. who are already infected with HIV, most of whom will need treatment treatment for drug abuse and HIV infection.

4. Additional costs of HIV infection for drug abuse treatment programs--psychological. While dealing with HIV infection within drug abuse treatment programs may be greatly increasing the financial costs of drug abuse treatment, the AIDS epidemic is placing an even greater burden on the morale of the programs' staff. The difficulties that the epidemic creates for the staff of treatment programs are so great than many programs in the country have not yet come to grips with the problem. Indeed, some programs still refuse to provide drug abuse treatment for persons with HIV infection.

Here, I will outline several of the more important morale problems that the AIDS epidemic has caused for the staff of drug abuse treatment programs. Before AIDS, death was very rare for clients in drug treatment programs. While there was a high death rate among drug users not in treatment, coming into treatment--and reducing or eliminating drug use--meant that the chances of dying from drug related causes almost disappeared. Now there are many clients in drug treatment programs who are dying from HIV related illnesses. These deaths involve protracted illness, with much pain--physical, psychological and spiritual.

HIV diseases strike not only those who continue to use illicit drugs, but also those who have successfully participated in treatment and stopped all use of illicit drugs. This includes treatment program staff who are ex-drug abusers. Helping clients and fellow staff members face death with a minimum of suffering and a maximum of dignity is a new task for our drug abuse treatment programs. Nothing in the traditional training of drug treatment staff prepared them to work with issues of death and dying, and it is definitely not a task that gets easier with practice.

While the issues related to (currently inevitable) death and dying are create a massive new burden for the staff of drug abuse treatment programs, issues of preserving life are also creating new heavy burdens for the staff. Staff must provide counseling on the difficult issues raised by potential heterosexual and perinatal

transmission of HIV. Let me simply cite two examples of these difficult counseling problems:

1. A former intravenous drug user wants to practice safer sex with his spouse, but is afraid that bringing up the issue will result in the spouse leaving him.

2. A female former intravenous drug user believes she has been exposed to HIV, wants to have a child before she develops AIDS, but is concerned that the child might be infected with the virus.

The new counseling demands that the AIDS epidemic is placing on the staff of drug abuse treatment programs involves great challenges in areas where most staff do not have adequate training. The potential for staff demoralization and burnout is very high.

5. Safer injection during periods of relapse. A final area in which the AIDS epidemic is dramatically changing drug abuse treatment programs is in the area of potential relapse. It has been repeatedly demonstrated that drug abuse treatment programs provide great benefits for the great majority of persons who enter treatment. Unfortunately, it is also clear that the great majority of persons with drug dependence problems will have one or more episodes of relapse during or after treatment. Traditionally drug treatment programs have either ignored the possibility of relapse or suggested that the client re-enter treatment as soon as possible after relapse. Now there is the possibility that a client may become infected with HIV during a relapse, either through unsafe drug injection or through unsafe sexual activity associated with drug use. Drug treatment programs thus need to teach their clients about both safer injection and safer sexual behavior in order to reduce the chances of HIV infection during relapse. Most drug treatment staff find this difficult to do in that it seems to undermine the needed confidence in the client's eventually achieving freedom from illicit drug use. The client's life may, however, depend upon the quality of this preparation for potential relapse.

Summary: We are currently in an unusual historical situation, about to greatly expand our drug abuse treatment system at the same time that the AIDS epidemic is forcing radical changes in the way we conduct drug abuse treatment. The challenges posed by the AIDS epidemic provide many ways in which an expansion of drug abuse treatment might fail. If such failures occur, they will be evident in high rates of HIV infection among drug users, demoralization and burnout among treatment staff and a continued high demand for illicit drugs in the United States.

There are several steps that need to be taken to greatly increase the chances that a large scale expansion of drug abuse treatment will succeed. First, AIDS prevention programming needs to be included in all drug abuse treatment programs. Second, extra resources will be needed in those areas where HIV infection among drug users is already causing greatly increased demands upon drug abuse treatment programs. Third, a system of monitoring and evaluation will be needed so that successful efforts can be replicated and either technical assistance or termination can be provided to efforts that are not succeeding.

Response to Questions from Senator Hatch

Prepared by Don C. Des Jarlais, Beth Israel Medical Center, New York, New York 10003.

1. There are three things that can be done to reduce staff burnout among drug treatment staff who now must work with numerous difficult AIDS issues in addition to their work with the problems of drug abuse. First, we need to provide more skill training so that the program staff will have the competencies to deal with issues such as sexual behavior and working with persons who are dying. Second, we need to form staff support groups within and across programs, so that staff can help each other through the difficult emotional issues that arise when working with AIDS and HIV infection. Third, we may have to increase salaries of drug treatment staff in order to compensate for the increased work load, skill requirements and emotional stress. Historically, staff in publicly funded drug treatment programs have been very poorly paid. Once they develop AIDS related skills, however, they are usually able to find much better paying positions.

2. The current spread of HIV among drug users is probably more rapid than in any other group in the country. We will need to do much more than simple "education" of persons whose drug use puts them at risk for exposure to HIV. Almost all of them already know how the virus is spread, and the great majority are already trying to change their behavior to reduce the risk of developing AIDS. We need to provide the means for them to change their behavior. We should provide immediate entry into drug abuse treatment for all persons who seek such treatment. We will also need to provide some means for "safer" injection for those who do not get into treatment or for whom treatment is not effective. Most developed countries are currently providing legal access to sterile injection equipment as a means of reducing HIV among drug users. In the United States, the provision of bleach to disinfect injection equipment is currently our major way of preventing the spread of HIV among drug users.

Given that the AIDS problem is likely to last at least another ten years, we also need to develop programs that reduce the number of persons who start to inject drugs. Findings from the limited number of studies that have been done in this areas indicate that simply telling persons at risk for injecting about AIDS does not scare them away from injecting. This is consistent with the general ineffectiveness of "fear arousal" techniques as a method of preventing drug use.

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The CHAIRMAN. Reverend Williams.

Reverend WILLIAMS. Good morning.

The CHAIRMAN. Reverend Williams is the director of Operations for the Addicts Rehabilitation Center in New York City. This center is the oldest in New York City. He will give us a perspective from the front lines on treatment needs in the war on drugs. And I think we are additionally to have your young daughter here today. We want to thank her very much for her patience.

If she would like to, she can come up to the table and sit with her daddy. Why don't you come on up?

Reverend WILLIAMS. It is important for me to have her with me today, because like some of the testimony of those who have gone before, at one point in my life I was addicted to drugs also, and had it not been for the availability of treatment I certainly would not be here, and I suspect neither would she.

The CHAIRMAN. Fine.

Reverend WILLIAMS. We are a residential drug-free treatment facility that houses 300 persons a day. We provide shelter, food and counseling services. Our service delivery system includes but is not limited to individual, family, and group counseling; we provide psychological and medical assistance as well as vocational educational assistance.

We are presently operating at about 135 percent of our capacity. We have a waiting list that approaches 500 persons. And while I cannot adequately describe the toughness of receiving 20 to 30 calls a day from persons desirous of getting help, I can indicate to you that when I left to come down here, I left about six people who had been sitting on a bench waiting for admission for anywhere between three and seven days, and that this waiting list is comprised of persons who, knowing that there is no room in the inn, come and sign the waiting list, fill out the appropriate papers, with the foreknowledge that they will have to wait approximately 4 to 5 months for treatment.

Needless to say, many of the persons who sign our waiting list and are turned away never get a second chance for us to offer any assistance. This is due in part because of a change in their motivational levels, or periods of incarceration, or a transient lifestyle, or the fact that they simply die.

I am encouraged by the Federal Government's willingness to begin to allocate the necessary financial resources needed if we are to actively engage in and ultimately win this war on drugs. While increases in funding is a step in the right direction, I am of the opinion that it is the priorities that will be set by you and this committee and the allocation of these funds that will really be the determining factor in terms of our chances for success.

We cannot win this war, in my opinion, if we continue to funnel moneys into the criminal justice system at the rate that we have been going, the law enforcement agencies, the courts and corrections. Neither can we win this war if we choose to write off the millions of Americans who are either experimenting with or hooked on drugs and try to concentrate on prevention strategies.

I believe that if we are to win, the blueprint for success must include funding for treatment. It appears to me that in all other wars, there are always provisions made for the casualties and vic-

tims of that war. I would submit that drug treatment must be viewed and funded as if it is our Red Cross in this drug war, and no longer as an afterthought or a stepchild.

The bureaucratic and administrative barriers that limit the expansion of our present treatment modalities and prohibit the use of Federal moneys for new construction need to be eliminated. At the same time, when we had a waiting list of 500 persons, we were engaged in trying to build a new facility, and Federal Government and State Government moneys prohibited the use of moneys for new construction.

Client support services that begin during treatment in residential drug programs must be continued and made available during the clients' aftercare period. If this continuum of care is broken even for short periods of time, the chances of that habilitated or rehabilitated client returning to drug abuse and its consequential criminal activities is greatly increased.

Criminal activity kind of anesthetizes the fact that we are talking about young women who are selling their bodies for $2 and $5 to buy drugs, or young men who are using guns and breaking in and committing hideous crimes in order to support drugs habits.

The availability of affordable and decent housing and job opportunities, stipend job training and vocational opportunities are directly linked to the successful treatment of substance abusers.

There should be money made available for drug abuse treatment so that any addict who seeks help is able to receive it up on request. To this end, I would urge your support of pending legislation that would allow Medicaid to cover the cost of substance abuse treatment and not just be limited to methadone.

I would agree with some of the comments made earlier about the need for a central registry in order that we might have knowledge of the availability and location of available treatment slots and monitor the progress and provide the needed research in this area.

As hard as it is for a person to get off drugs, it is virtually impossible for them to stay off drugs unless there are some support systems in place. I would just urge that we allocate those moneys to do that.

I would also like to go on record as saying that the $31,000 figure for drug treatment is excessively high as indicated by our programs, and there need to be some additional moneys for treatment. We have an overdependence upon methadone that has proven inefficient and ineffective in the treatment of crack and cocaine addiction.

Thank you very much.

The CHAIRMAN. Thank you very much.

[The prepared statement of Reverend Williams and an additional statement supplied for the record from the American Psychological Association, also questions and responses from Dr. Schuster follow:]

## PREPARED STATEMENT OF REVEREND REGINALD WILLIAMS

GOOD MORNING SENATORS

MY NAME IS REVEREND REGINALD WILLIAMS AND I AM THE DIRECTOR OF OPERATIONS FOR THE ADDICTS AND REHABILITATION CENTER, 1881 PARK AVENUE, NEW YORK, NEW YORK.

THE ADDICTS REHABILITATION CENTER, COMMONLY REFERRED AS ARC, WAS FOUNDED IN 1957 BY MR. JAMES ALLEN AND IS THE OLDEST DRUG TREATMENT PROGRAM IN THE STATE OF NEW YORK. WE HAVE BEEN PROVIDING DRUG TREATMENT SERVICES TO OUR COMMUNITY FOR 32 YEARS.

WE ARE A DRUG FREE RESIDENTIAL TREATMENT FACILITY THAT HOUSES, FEEDS AND TREATS MORE THAN 300 DRUG ABUSERS A DAY. OUR SERVICE DELIVERY SYSTEM INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING: INDIVIDUAL GROUP AND FAMILY COUNSELING, VOCATIONAL EDUCATION AND PLACEMENT, MEDICAL AND PHYSIOLOGICAL ASSISTANCE AND DRUG PREVENTIVE EDUCATION.

WE ARE PRESENTLY OPERATING AT 135 PER CENT CAPACITY WITH A WAITING LIST OF APPROXIMATELY 500 PERSONS. WHILE I CANNOT BEGIN

TO EXPRESS THE HUMAN TRAGEDY OF HAVING TO TURN PEOPLE AWAY WHO ARE SEEKING HELP, I CAN TELL YOU THAT IN ORDER TO BE PLACED ON OUR WAITING LIST SUBSTANCE ABUSERS MUST PHYSICALLY APPEAR AT OUR FACILITY AND FILL OUT THE NECESSARY PAPERWORK KNOWING THAT "THERE'S NO ROOM AT THE INN" AND THAT THEY WILL BE FORCED TO WAIT APPROXIMATELY 5 TO 6 MONTHS FOR ADMISSION AND TREATMENT. NEEDLESS TO SAY, MANY OF THE PERSONS WHO COME SEEKING OUR HELP ARE NEVER GIVEN ANOTHER OPPORTUNITY FOR A DRUG FREE LIFE. DUE TO THE RISKS INHERENT IN THEIR LIFESTYLE, A DELAY CAN RESULT IN INCARCERATION OR DEATH.

I AM ENCOURAGED BY THE FEDERAL GOVERNMENT'S WILLINESS TO BEGIN TO ALLOCATE THE NECESSARY FINANCIAL RESOURCES NEEDED IF WE ARE TO ACTIVELY ENGAGE, AND UTIMATELY WIN " THE WAR ON DRUGS." YET WHILE INCREASES IN FUNDING ARE A STEP IN THE RIGHT DIRECTION, YOUR PRIORITIZATION AND ALLOCATION OF THESE FUNDS WILL DETERMINE OUR CHANCES OF SUCCESS. WE CANNOT WIN THIS WAR IF THE BULK OF MONIES ARE CONTINUALLY FUNNELLED INTO THE CRIMINAL JUSTICE SYSTEM.

WE CANNOT WIN THIS WAR IF WE CHOOSE TO WRITE OFF THE MILLIONS OF AMERICANS WHO ARE EXPERIMENTING WITH OR ARE ADDICTED TO DRUGS AND CHOOSE TO CONCENTRATE ONLY ON PREVENTION STRATEGIES AND CATCHY SLOGANS. IF WE ARE TO WIN THIS WAR, OUR BLUEPRINT FOR

SUCCESS MUST INCLUDE INCREASED FUNDING FOR TREATMENT. IN ALL THE WARS THAT ARE WAGED, THERE IS ALWAYS PROVISION FOR THE CASUALTIES OF THE WAR. DRUG TREATMENT MUST BE VIEWED AND FUNDED AS IF IT IS OUR RED CROSS IN THIS DRUG WAR AND NO LONGER TREATED AS AN AFTER THOUGHT OR A STEPCHILD.

CLIENT SUPPORT SERVICES THAT BEGAN DURING TREATMENT IN A RESIDENTAL DRUG FACILITY MUST BE MADE AVAILABLE DURING THE CLIENT'S AFTER CARE. IF THIS CONTINUITY OF CARE IS BROKEN EVEN FOR A SHORT PERIOD OF TIME, THE CHANCES OF THAT REHABILITATED CLIENT RETURNING TO DRUG USE AND ITS CONSEQUENT CRIMINAL ACTIVITIES ARE GREATLY INCREASED.

THE AVAILABILITY OF DECENT AND AFFORDABLE HOUSING, JOB TRAINING, AND VOCATIONAL OPPORTUNITY ARE DIRECTLY LINKED TO SUCCESSFUL TREATMENT OF SUBSTANCE ABUSERS.
AS DIFFICULT AS IT IS TO KICK A DRUG HABIT, IT IS TWICE AS HARD TO REMAIN DRUG FREE WITHOUT THESE NECESSSARY SUPPORT SERVICES. THERE SHOULD BE ENOUGH MADE AVAILABLE FOR DRUG ABUSE TREATMENT SO THAT ANY ADDICT THAT SEEKS HELP CAN RECEIVE IT UPON REQUEST. TO THIS END, I URGE YOU TO SUPPORT INCREASED FUNDING OF TREATMENT PROGRAMS AND ALSO PENDING LEGISLATION THAT WOULD ALLOW MEDICAID TO COVER THE COST OF SUBSTANCE ABUSE TREATMENT AND NOT JUST BE LIMITED TO METHADONE, WHICH HAS PROVEN NOT TO BE EFFECTIVE IN THE TREATMENT OF COCAINE AND CRACK ADDICTION.

# PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

## I. INTRODUCTION

The American Psychological Association (APA), the leading scientific and professional society representing over 90,000 clinicians, researchers, educators, consultants and students, is pleased to have this opportunity to submit testimony for the Senate Labor and Human Resources Committee's Hearing on Drug Abuse Treatment. Psychology plays an integral role in drug abuse treatment, rehabilitation and prevention. Every day our members working with drug and alcohol dependent patients see the devastating toll this problem takes on individual mental health, family structure and society as a whole.

The APA applauds the Committee for taking the lead in redirecting our policy makers' attention on "demand-side" issues of drug abuse. Psychologists and other health care professionals involved in the treatment of individuals with drug abuse problems have long been concerned with the lack of focus on and funding for drug treatment and prevention programs. We believe that with the Committee's leadership, that trend will shift to more awareness of the need to address the individual and societal problems that cause people to turn to alcohol and drugs. We are also hopeful that there will be in increase in services that can curtail or prevent drug abuse.

Psychologists, as professionals with extensive training in human behavior, have much to offer in the delivery of effective treatment services as well as drug abuse research and education. This testimony will reiterate the scope of the drug abuse problem in America; identify the need for drug treatment and prevention programs; and will summarize current findings regarding drug abuse treatment and prevention and make recommendations for the future.

## II. THE NEED FOR INCREASED EMPHASIS ON DRUG TREATMENT AND PREVENTION PROGRAMS

### A. The Problem and Costs to Society

Every day we are reminded of the pervasiveness and severity of the drug abuse problem in the United States. Our neighborhoods are becoming war zones, heavy addiction is on the rise and it seems as though current anti-drug policies are not making enough of an impact on the problem. A 1985 survey found that 23 million Americans had used an illegal drug in the past month and that 6.5 million were severely dependent on heroin, other opiates, amphetamines, and cocaine. Nearly 24% of employed males aged 18-24 and 21% aged 25-34 use marijuana at least once a month (NIDA, 1985). In 1987, 42% of high school seniors reported using an illicit drug in the past year. Over 10% had used cocaine in the past year and over 4% had used cocaine in the past month (NIDA, 1987).

A 1989 household survey reveals that while casual drug use may be declining somewhat, heavy use of drugs such as crack and cocaine is on the rise. Furthermore, the survey shows that women are now more likely to use crack/cocaine and even heroin (NIDA, 1989). Until recently, heavy drug use was concentrated among males. The recent Washington Post profile of Dooney

Waters, the 6-year old boy who spent his early childhood living in a crack house with his drug dependent mother, illustrates the tragic family consequences of the current crack/cocaine market. Children who are repeatedly exposed to drugs and violence suffer psychological trauma and often exhibit symptoms of introverted behavior, phobias, nightmares, violent outbursts, diminished expectations for the future, hyperactivity or extreme listlessness and an inability to trust others or form close relationships.

Too little attention is paid to the effects of drug abuse on the health and well-being of our children. Repeated exposure to family drug abuse undoubtedly has long-term effects associated with juvenile delinquency, school drop-outs, run aways and drug abuse. One study of adolescents enrolled in residential drug treatment centers found that a majority of the participants reported family alcohol or drug abuse. These children most often came from single parent homes and majority had been arrested at least once in the past year (Cator Report 1987).

Heavy drug use among children and adolescents remains high (NIDA, 1989). As stated previously, over 42% of the students surveyed had used an illicit drug at least once in the past year. Furthermore, nearly 5% reported using one or more illicit drugs on a daily basis during the prior month. These patterns suggest that many adolescents are past the "experimental" stage of drug use and that many will or do suffer from serious physical, mental, and/or social effects (Radhert, 1988). Children are especially vulnerable and are all too frequently the victims of the direct and indirect harm caused by drug abuse.

There is no question as to the link between drug abuse and crime. Current statistics indicate that approximately three-quarters of arrested individuals in major cities tested positive for illegal drugs. Up to one-half of all felony indictments in major cities involve violations of drug laws and it is estimated that 70% of all violent crime in the U.S. is drug-related. (White House Conference on Drug Abuse, 1988).

Drug abuse also puts enormous pressure on our health care delivery systems. Between 1985 and 1988, cocaine-related emergency room admissions reported in 21 major cities increased 227%. In 1986, emergency rooms reported 120,000 drug abuse episodes, over 10% involving 10 to 17 year olds. (NIDA 1989).

Finally, we cannot ignore the economic impact associated with drug abuse in the workplace. One study on this issue suggests that drug users are 3.6 times more likely to be involved in plant accidents and 2.5 times more likely to require absences lasting more than a week as compared to workers who do not use drugs or alcohol and function at about 67% of their work potential (Cohen, 1983). It is estimated that the annual cost to society of drug and alcohol abuse will reach $229 billion in 1990 (The Robert Wood Johnson Foundation, 1989). These costs include diminished workforce productivity, increased demands on health care, law enforcement, judicial, and corrections systems. Other studies have estimated that alcoholism alone currently costs over $100 billion per year, mostly due to lost productivity. Many believe that

substance abuse is the nation's number one problem in terms of costs to the economy (Holder, 1987)

B. Comment on the Factors Associated with Drug Abuse

A wide variety of factors contribute to drug abuse including psychosocial influences such as poverty, peer pressure, work- or family-related stress, divorce, absentee parents, child abuse and neglect. An inextricable component is individual mental health. In some instances drug abuse represents an attempt at self-medication for depression, anxiety or other psychological disorders (O'Brien, et al., 1984). The authors of several articles and studies on drug dependency have noted "...the high degree of psychopathology displayed by opiate addicts and that use of illicit substances frequently occurs in response to psychiatric symptoms" (O'Brien et al., 1984).

A majority of drug addiction cases are associated with some form of psychological disorder. Recent studies indicate that the types of psychological problems observed with addicts are similar to conditions which are often treated with psychotherapy when they occur in non-addict populations (Rounsaville, 1981). The National Institute on Drug Abuse (NIDA) reports that one-half to two-thirds of all drug addiction is linked to individual depression (Ginzburg, 1988).

There is a very high incidence of delinquency among adolescent drug users. Evidence suggests that efforts to prevent adolescent drug abuse and chronic serious delinquency should target the same factors (Hawkins, 1987). The authors of a recent study of adolescent drug use found a significant relationship between early drug usage and several scores reflecting maladjustment, including antisocial behavior, coercive behavior with family members, self-esteem, and depression (Dishion, 1988). This data points to the special need for early diagnosis, treatment, and prevention efforts tailored to high risk youth and their families.

III. CURRENT RESEARCH ON EFFECTIVENESS OF TREATMENT AND PREVENTION OF DRUG ABUSE

A. Treatment

There now exists a large body of research that provides convincing evidence that drug abuse treatment works. Two notable large scale research projects established to evaluate the effectiveness of existing treatment programs are the Treatment Outcome Prospective Study (TOPS) a NIDA supported study using treatment data from 1979 to 1981 and the Drug Abuse Reporting Program (DARP) established by NIDA in 1969. TOPS and DARP are longitudinal, multidimensional programs representing a turning point in state-of-the-art drug treatment outcome studies. Several evaluations written based on TOPS and DARP data conclude that almost all forms of drug abuse treatment are effective in producing significant improvements in reducing use of illicit drugs, reducing

criminality, improving employment and social productivity and improving mental health (Simpson, 1984; Hubbard, 1984). For example, one evaluation of DARP revealed that outcomes from therapeutic communities and outpatient drug-free programs were quite favorable. Of all subjects, 43.6% had favorable outcomes as characterized by drug abstinence and little or no criminality; 29% had moderately favorable outcomes, characterized by moderate drug use, moderate unemployment and by a substantial degree of return to treatment (Cross, 1988). In addition, smaller studies such as that summarized in the CATOR Report of 1988 also report favorable results of various treatment programs (CATOR 1988 Report). Furthermore, based on current literature and data, NIDA maintains that individuals in treatment programs across the board, show significantly improved behaviors consequent to leaving treatment (NIDA, 1988).

The four major treatment programs commonly recognized in the health community and which are the subject of treatment evaluation studies are 1) Therapeutic Communities; 2) Drug-free outpatient settings; 3) Methadone Maintenance; and 4) Detoxification. NIDA reports that studies show in general, each has yielded favorable results. This is true especially when the treatment includes drug counseling or psychotherapy as part of its overall approach (O'Brien, 1984).

Therapeutic communities are full-time, drug-free residential programs which are highly organized and provide, for example, peer support and confrontation. Outcome research indicates that this mode of treatment is effective as measured by decrease in drug use, criminality and prosocial behavior. Drug-free Treatment encompasses a wide variety of treatment modalities including self-help groups and psychotherapy. Methadone maintenance involves replacing street heroin with methadone, a synthetic opiate that allows the client to stabilize and through counseling and education, explore options for curbing drug dependency. Finally, detoxification is a method intended to help achieve abstinence by prescribing, under medical supervision, gradual decreases in doses of methadone. Both methadone maintenance and detoxification may also involve other treatment modalities such as drug counseling or psychotherapy and all programs except those that are residential may incorporate a combination of treatment modalities in an inpatient or outpatient setting.

In each of these programs, success is measured by abstinence or decrease in drug use, decreased criminal activity and increased productivity. There are certain factors which seem to enhance the effectiveness of treatment. One such factor, an important predictor of successful treatment, is the inclusion of some form of drug counseling, or group, individual or family therapy. Most completed studies to date suggest that treatment success is significantly improved when comprehensive therapy is included in the treatment program (O'Brien, 1984).

Length of stay in a treatment program is also considered to be an important factor in treatment efficacy. Studies evaluating therapeutic communities show better results for individuals who spend several months in the program and striking improvements for those who finish the program (DeLeon, 1984). Long-term programs (three months or more) generally have much lower relapse rates

than shorter programs. In general, individuals in longer term programs experience less relapse and greater recovery rates (Simpson, 1985; McAuliffe, 1985).

Patient-treatment matching is commanding more attention from the treatment community especially in light of the increasing variety of treatment programs. Furthermore, individuals in drug treatment often have a multitude of problems which points to the need for comprehensive assessment and treatment matching. Matching a patient's specific needs to treatment components enhances treatment efficacy and helps researchers better understand the complex nature of substance abuse. Studies on the effectiveness of alcohol treatment have demonstrated the positive effects of patient-treatment matching. In one study the overall outcome of the matched patients was 19% better than that of a control group (McLellan, 1987).

B. Prevention

The issue of prevention and early intervention deserves special attention. Until recently, prevention efforts have been overlooked and may well be one of our most effective, cost-efficient tools for fighting substance abuse. Prevention and early intervention is especially significant with children and adolescents. As mentioned previously, children are frequently the direct and indirect victims of substance abuse. It is found that many children who enroll in drug treatment programs grew up with family members who also had substance abuse problems.

The data on frequent drug use among adolescents are staggering. According to the 1988 NIDA survey, a quarter (1/4) of a billion youngsters age 12 to 17 were currently using crack or some other form of cocaine when responding in 1988 (NIDA, 1989). The frequency of drug use among this population is extreme, but may well underestimate the problem because of the difficulty of obtaining data on runaways, drop-outs and the homeless, all of whom are at-risk for drug abuse.

A key to any successful prevention effort is getting accurate information to those who are at risk of substance abuse. This is especially important in light of the growing popularity of crack and other forms of cocaine which are highly addictive, cause severe physical and psychological problems and are subject to many misconceptions that require increased emphasis on drug education (NIDA, 1986). It is believed that the most promising programs are those initiated during the early adolescent years which have been identified as the first risk period for the "gateway" drugs of tobacco, alcohol and marijuana. These programs focus on delaying use or abuse of any of the "gateway" drugs (Pentz, et al., 1989).

School-based programs have been found to be effective in preventing future drug use. The programs studied include cognitive models which increase students' knowledge of the pharmacological effects and physical and social hazards of abuse an mold attitudes and beliefs supportive of drug abstinence;

affective and interpersonal programs which strengthen the child's emotional and psychological resources by improving self-concept and social and psychological development and adjustment; behavioral programs which use instruction, role playing, feedback, and reinforcement to increase resistance to social pressures; environmental programs designed to establish and enforce tougher school drug policies and coordinate school prevention efforts and special programming; and therapeutic models which focus on early identification, referral and counseling for students (Bukoski, 1985).

Unfortunately, there is a paucity of concrete data on the effectiveness of drug prevention and intervention programs. However, the prevention studies that have been completed indicate substantial positive influence on future drug resistance (Pentz, 1989; Tobler, 1986). Prevention programs take many forms and there is a concensus among experts that any prevention efforts must take a comprehensive approach. A sound prevention program should include mass-media campaigns, community-based programs, education of parents, school-based programs and health policy reforms designed to change attitudes and behaviors about drug abuse (Pentz, 1989).

C. Early Intervention

Implicit in any discussion of treatment and prevention is the issue of early intervention. Intervention concentrates on the identification of persons whose behavior puts them at risk for drug abuse and persons in the early stages of drug use. The purpose of intervention is to reverse the early stages of dysfunction of the individuals or groups at risk. Components of a comprehensive intervention strategy should include the training of primary health care professionals to recognize drug related problems; screening for early identification of drug abuse; and intervention and assistance through employee assistance plans (EAPs) or other comprehensive drug abuse programs (Second Triennial Report to Congress, 1987).

There has been an encouraging trend toward early intervention and treatment among adolescents who, as mentioned previously, are entering the first high-risk stage for substance abuse. Identification of those abusing alcohol and drugs is being made an earlier stage of involvement by a wide range of professionals and agencies including teachers and school administrators, juvenile justice system officials, and therapists and counselors. Additionally, more attention should be placed on the diagnostic or assessment process for this population. The nature of drug abuse is changing and adolescent care should not be based solely on adult models. Assessments will be needed to pinpoint the actual problems that may be concomitant with drug abuse and will therefore require the development of more detailed and multifaced procedures in order to ensure the most effective course of treatment (Winters, 1988).

Not only have substance abuse treatment, intervention and prevention programs proven effective in improving the lives of millions of at-risk or chemically dependent individuals and their families, substance abuse treatment and prevention programs are also defensible on the basis of economic benefit to

society. Treatment and prevention result in increased worker productivity, and decreased strain on our judicial and correctional systems not to mention substantial savings in health care costs (Simpson, 1984). A 1984 review of outcome studies concludes that "Treatment for alcohol and other substance abuse appears to have an extremely significant potential for economic payback to local state and federal governments, insurance providers, corrections agencies, private industry, and, of course, patients and their families (Holder and Blose, 1986; Hoffman, 1984: p.83). When compared to the cost of enforcement activities such as incarceration of drug law offenders it makes one wonder why we have spent so little public money on treatment and prevention and so much on enforcement and interdiction. For example, the annual cost for each prisoner in a maximum security facility is approximately $30,000 and the cost for a comprehensive substance abuse treatment program often is as little as $4,000.

IV. RECOMMENDATIONS

1. LONG-TERM STRATEGY: We are well aware that there are no quick fixes for our nation's growing drug abuse crisis. More stringent enforcement and tougher penalties for drug activity have had some sucess but most will agree enforcement is an inadequate long-term solution to drug abuse. We encourage policy makers to set long-term goals for reducing drug dependency and develop a coordinated intragovernmental strategy for reaching those goals. Such a plan should be developed in close consultation with mental health and health care professionals working as providers, educators and researchers.

2. RATIONAL FUNDING: More resources should be concentrated on "demand reduction" programs. While there has been a recent shift in the past practice of spending billions more on "supply-reduction" programs of law enforcement and interdiction, the Administration has failed to include adequate funding for drug rehabilitation and treatment, and Congress has failed to fully fund treatment programs authorized under current law. We urge Congress and the administration to work together to remove the roadblocks to the funding of current programs, to move forward with expanded initiatives, and to create new payment structures for services through existing federal health insurance programs. More funds should also be allocated for research initiatives in the areas of prevention, diagnosis, treatment and treatment outcome assessment. Congress should explore cooperative efforts designed to streamline the treatment system, coordinate care and improve case management.

In addition, special efforts must be made to reduce the waiting lists for treatment. It is estimated that there are approximately 35,000 people who will be unable to get treatment slots in major U.S. cities and that anywhere between 40% to 90% of all people voluntarily seeking treatment are turned away each year. New, expanded programs are to ensure the inclusion of those seeking treatment such as programs designed to provide pretreatment services including where appropriate, diagnosis and some form of counseling or therapy.

3. TARGET TREATMENT PROGRAMS TO MEET SPECIAL NEEDS: Some populations will not benefit from established forms of treatment programs. They have special needs that must be taken into consideration. Children, for example, may not do as well with traditionally adult models of treatment; women of child-bearing age need special educational efforts aimed at prenatal care and services to care for their children. Policymakers must guard against viewing treatment in rigid models and must support development of policies that allow individuals the opportunity to acess flexible, multifaceted programs.

4. IMPROVE DRUG ABUSE EDUCATION THROUGHOUT EDUCATIONAL AND SOCIAL PROGRAMS: Drug prevention begins in the home, schools and in the community. We need efforts for outreach to populations at risk and to provide education for the general population about the dangers of drug abuse. It is critical that these efforts focus on misconceptions about drug abuse (see previous discussion regarding the nature of crack/cocaine addiction). These efforts should also concentrate on overcoming the barriers, misconceptions and biases that add to the local resistance to treatment centers.

7. MANDATED INSURANCE BENEFITS FOR TREATMENT: Insurance companies and self-insured companies should be required to provide or make available coverage for drug abuse treatment. Currently thirty-eight (38) states and the District of Columbia require that private health insurers either cover or offer coverage for alcoholism treatment services. Twenty-one (21) states and the District of Columbia now mandate the coverage or the offering of drug dependency treatment service benefits.

8. MORE EMPLOYER INVOLVEMENT IN DRUG ABUSE DETECTION AND TREATMENT: Employers should be encouraged to take more responsibility in the detection and treatment of substance abuse problems among their employees through mechanisms such as tax incentives and public/private partnerships. Employers should be encouraged to establish employee assistance plans (EAPs) which provide for drug and alcohol education, early intervention and treatment and which include options for outpatient as well as inpatient care. Only 25% of all American workers are currently covered
by EAPs (NIDA, 1989).

9. BETTER COORDINATION BETWEEN DRUG ABUSE TREATMENT FACILITIES AND EXISTING HEALTH CARE SYSTEMS: Drug treatment programs are often run as entities separate from other local heath care facilities. This creates an additional tier of health care services, increases costs and creates unnecessary stigma. Drug abuse officials should work with the administrators of existing health care and mental health care systems to develop joint efforts to lower costs, share resources and improve the quality of services for treating drug dependency.

SENATOR MIKULSKI'S QUESTIONS

Q. You mentioned the need to match treatment to different kinds of drug abusers. But you categorize different kinds of drug abusers by the likelihood of seeing a positive result.

I'd like to ask you about a different kind of categorization -- do you think that different kinds of drug users, such as women and minorities, need different kinds of treatments? Is there differential effectiveness of different kinds of programs for these different groups?

A. Regarding the question of differential effectiveness of special treatments for drug abusers who are women or minority persons, no studies comparing outcomes for generic treatments and treatments tailored to the special needs of those populations have been done, but there are reasons to believe that they could benefit from special interventions. Of particular concern are pregnant women and women with child care needs. We are currently conducting demonstration projects examining effectiveness of different strategies for providing more comprehensive medical services to pregnant addicts and their newborn children. There is also evidence that unmet child care needs present an impediment to recruiting and retaining women into drug treatment. We are supporting demonstration projects which will incorporate child care into treatment programming, in the expectation that by meeting these needs, the welfare of the children will be enhanced and the drug dependent mothers will be more likely to remain in treatment. Regarding the special needs of minority and special populations, it is essential that drug treatment programs be sensitive to these needs. These needs may be rooted in the socioeconomic conditions in the community or may arise out of language or cultural differences. An example of needs arising out of culture may be seen in some Hispanic populations where models of family therapy are being tested. One such model, intergenerational family therapy, draws on the especially strong kinship ties in the extended family among Mexican-Americans. In addition, language barriers and special service needs point up the need for special, culture-sensitive programs.

Q. A lot of your statement was focused on the development of 'addiction treatment medications.' I am concerned that if we do develop an effective 'medication, to treat drug abuse, that we don't narrow the focus of our treatment to simply the provision of the medication without supportive services to address the lifestyle of the drug abuser. Have your clinical trials looked at the effectiveness of some combination of medication and supportive services and compared this with the provision of medication alone?

A. The National Institute on Drug Abuse is addressing the development of treatments for drug abuse from a number of approaches. While medications development (such as possibly using

tricyclic antidepressants in treating cocaine abusers) is a priority here, we are mindful of the adjunctive role of pharmacological treatments and are committed to rehabilitation as a central concern of treatment. In answer to your specific question, we have sponsored research on the independent and joint effects of pharmacological treatment and psychotherapies/rehabilitative services. For example, Dr. Bruce Rounsaville of Yale University Medical School is currently conducting clinical trials of desipramine alone versus desipramine and relapse prevention training only in a sample of cocaine abusers. Dr. John Grabowski of the University of Texas is now beginning clinical trials of antidepressants and behavior therapies for cocaine abusers, using a design that assesses the effects of antidepressants alone and in conjunction with behavior therapies. Dr. Jeff Hoffman of KOBA Institute in Washington, D.C., is also conducting controlled trials of antidepressants, dopamine agonists, and psychosocial interventions. In other studies, we have various examinations of the relative efficacy of different levels of counseling and services in programs where medication is not varied, as in Dr. Anna Rose Childress of the University of Pennsylvania's study of three levels of methadone maintenance treatment.

In summary, NIDA supports an ongoing program of research and demonstrations which give careful attention to the role of supportive services in treating drug abuse.

SENATOR HATCH'S QUESTIONS

Q. Dr. Schuster, in your prepared statement you comment about the incentives of the Orphan Product Act and its positive impact on medication development. The Orphan Product Act was designed for those diseases for which there are few cases, far fewer than those addicted to drugs. In fact, this was an issue on the Floor when we were debating the drug bill. Are you aware that we passed an amendment to S.1735 that provided incentives similar to the Orphan Drug Act for medication development?

A. Yes, I am aware of the effort to include the development of medications for addictive disorders under the rubric of orphan diseases. As I have indicated, this is a very positive movement. Already we have received indications from a number of major pharmaceutical firms that they would become more heavily invested in the development of medications for drug addiction if this amendment becomes law. Drug abuse is a unique disease in that most people who suffer from this condition do not seek medical care. While the number of people who are addicted to heroin, for example, may number upwards of one million, at any given time less than 200,000 seek treatment for their condition. Moreover, as I have already mentioned, because of various economic and social considerations, pharmaceutical firms have not attempted to develop medications for addictive disorders thereby making this a de facto orphan disease. Considerations include: (1) Drug dependent people do not necessarily seek treatment and may even avoid it. Thus, they may be seen as a limited market. (2) Up until recently, the number of drug abusers, while large, has traditionally not been seen as large enough to be even potentially economically rewarding. (3) Some medications that might be developed are either off patent or about to come off patent. Lack of patent protection may significantly reduce the profitability of new medications. (4) Many pharmaceutical companies are concerned about having their products associated in the public's mind with "junkies". Moreover, research on this population is difficult and not attractive to many investigators. (5) Medications for drug abusers may have their application to other medical indications severely restricted for various reasons, including placement on an unacceptable schedule under the Controlled Substances Act. (6) Pharmaceutical companies are concerned about various liability issues, some of which--for example, treatment of pregnant drug abusers--are of very real concern.

Q. Dr. Schuster, how many medications does NIDA currently have under development either within the Agency or under contract to treat drug addiction?

A. We have about twenty different treatment agents under active consideration as potential pharmacotherapies for drug addiction. Six are undergoing or have completed clinical trials for safety and efficacy. During the current fiscal year we anticipate initiating

clinical trials on approximately six to eight additional compounds. Many of these compounds are being tested in collaborative efforts involving the pharmaceutical industry and NIDA's Medications Development Program. This type of federal-private sector collaboration has proven quite successful in developing new treatment agents for epilepsy, cancer, and AIDS.

Q. NIDA is to be congratulated for the efforts that are currently underway to develop medications to treat drug addiction. One of the things that has struck me is the ability of man to become addicted and find new chemicals when the old ones are either not available or too costly. How does NIDA track newly emerging trends in drug abuse, and what changes do you see emerging?

A. NIDA has a number of ongoing epidemiologic activities which are used to monitor patterns and trends in drug abuse and identify potentially emerging problems. One of the major sources of information is the National Household Survey on Drug Abuse. The scope of this National Survey has expanded over the years with recent surveys assessing drug abuse prevalence in the household population of the United States for a number of substances including: marijuana, cocaine, hallucinogens, psychotherapeutic drugs, alcohol and cigarettes. The National Household Survey on Drug Abuse has been sponsored by NIDA since 1974 and is conducted every two to three years with the latest occurring in 1988. The next survey is scheduled for 1990.

This national prevalence survey remains the single most important measure of drug abuse on our population. The methodology has been comparable for all of the surveys: respondents are interviewed in their homes by trained interviewers using a combination of interviewer administered and self-administered answer sheets and standardized methods to maximize response validity. All data are confidential and anonymous. Respondents are randomly selected within age categories from a multi-stage national probability sample. In 1988, as in previous surveys, young people (12-34 years of age) were oversampled in order to obtain more stable estimates of drug use for that group. Blacks and Hispanics have been oversampled since the 1985 survey.

A second large-scale epidemiological survey of drug use, the Monitoring the Future Study, was initiated in 1975 through a grant awarded by NIDA to the University of Michigan's Institute for Social Research. The survey is based on a multi-stage probability sample of approximately 17,000 public and private high school seniors. This survey measures drug abuse prevalence among high school seniors and is conducted annually in order to monitor trends in drug abuse and related attitudes. As with the National Household Survey on Drug Abuse, this survey is a national

probability study designed to be representative of the population surveyed. Although high school seniors represent a very specific population, we believe the findings pertaining to them are very important because young people are often at the leading edge of social change. We expect data from the 1989 survey to be available early in 1990.

Another major source of data for NIDA is the Drug Abuse Warning Network (DAWN). DAWN is a large-scale, ongoing drug abuse data collection system which is sponsored by NIDA. DAWN data are collected from a nonrandom sample of emergency room and medical examiner facilities. DAWN collects information only about those drug abuse occurrences which have resulted in an emergency room episode and/or death. The major objectives of the DAWN data system include: the monitoring of drug abuse patterns and trends, identification of substances associated with drug abuse episodes, and the assessment of health hazards associated with drug abuse. The emergency room data in DAWN are from facilities located primarily in 21 metropolitan areas throughout the continental United States and a National Panel of emergency rooms. The medical examiner data are collected from 27 metropolitan areas. Within each participating facility, a designated DAWN reporter is responsible for identifying drug abuse episodes by reviewing official records and transcribing and submitting data on each case. A number of quality control procedures are used to assure that DAWN data are as accurate and methodologically consistent as possible. It is important to note that an emergency room episode or death may involve multiple drug mentions. For this reason, not every reported substance is, by itself, necessarily a cause of the medical emergency or death.

In addition to the three primary data sets discussed, NIDA uses many other data sets to measure the nature and extent of drug use. In conjunction with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIDA sponsors the National Drug and Alcoholism Treatment Unit Survey (NDATUS) and the State Alcohol and Drug Abuse Profile (SADAP). NIDA supports research on all aspects of drug abuse and the special needs populations involved by funding many grants and special studies. Included in NIDA grants is one for the mathematical model estimation of heroin use.

Another collaborative effort of NIDA is the National Adolescent Student Health Survey (NASHS). NIDA has also supported the addition of drug abuse question on several other National Center for Health Statistics surveys, the 1988 National Maternal and Infant Health Survey (NMIHS) and the Hispanic Health and Nutrition Examination Survey (HHANES). NIDA also funded drug related questions on the Bureau of Labor Statistics' National Longitudinal Survey (NLS). In addition to collaborative efforts, NIDA uses

other data bases where appropriate including Drug Use Forecasting (DUF) and the Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel.

Additionally strengthening the capacity of State and local agencies and drug abuse epidemiologists to collect data on area drug problems has long been a goal of NIDA's surveillance program, largely because it is through these channels that accurate information can be obtained and disseminated. To this end, NIDA sponsors the Community Epidemiology Work Group (CEWG) and State Epidemiology Work Groups (SEWGs) both of which serve to describe local area drug abuse patterns and trends, to identify emerging drugs of abuse, to determine populations with special risks for drug abuse, and to develop improved data collection methods and indicators for problem assessment. NIDA's ongoing support of CEWG and SEWGs will be critical during the 1990's for these activities provide a community basis for evaluating progress in drug abuse reduction. Furthermore, the number of States forming SEWGs is increasing rapidly with as many as 14 conducting work group programs in 1989.

Major national trends in drug abuse have been provided in previous testimony. However, a number of drug abuse indicators suggest an increasing trend of methamphetamine abuse on the mainland U.S. particularly in West Coast cities. The Drug Abuse Warning Network Emergency Room data show statistically significant increases in mentions of methamphetamine/speed. During the last half of 1988, DAWN showed a 70 percent increase over the six month period from July to December 1988. In 1988, there were 3,030 mentions of methamphetamine use among drug abuse-related emergency room cases. The largest number of methamphetamine mentions occurred in Dallas, Phoenix, San Diego, Los Angeles, San Francisco, and Seattle. The proportion of mentions related to the smoking route of administration ranged from 1.6 percent in Dallas to 4.8 percent in Los Angeles.

Trends in these and other drug specific mentions are monitored continuously through current data systems and field investigations.

Q. Dr. Schuster, in your prepared statement you indicate a need to change our Nation's attitude of acceptance to an attitude of intolerance to drug abuse. Would you please describe how you think we can best achieve this objective?

A. The key to stopping the drug use problem in America is prevention and NIDA's research indicates that drug abuse prevention works! Drug abuse is both a health and social issue. Every American needs to know that drug use can result in adverse acute and chronic negative health effects and constitutes a socially irresponsible act that threatens the safety and effective

functioning of families, schools, the workplace, and community life in general. These objectives can be reached by comprehensive drug abuse prevention that effectively combines media; drug education in the schools; drug-free policies in schools, the workplace and communities; parent education and organization; community mobilization; and, persistent deterrence through local law enforcement.

NIDA's research indicates that the decline in use of marijuana over the last decade and the more recent decline in cocaine use, has resulted from an increased perception of the harmful consequences of drug use and increased personal and social disapproval of the use of illicit substances. These changes occurred in part as a result of the sustained implementation of drug abuse prevention media campaigns, such as the one mounted by the Advertising Partnership for a Drug Free America; the delivery of scientifically accurate drug information and peer resistance training in the schools; the direct involvement of concerned parents and community leaders to form drug prevention coalitions at the local level; and, the implementation of clear and fair drug policies in the workplace that includes drug testing where appropriate. All of these actions together are beginning to establish in America a change in awareness, attitudes, and behavioral norms that characterize societal intolerance to drug use. Prevention programs are working, and need to continue this year and in the future to expand prevention to reach all cultural groups within our society, particularly those communities impacted by drugs, such as crack cocaine and, potentially, crystal methamphetamine or 'ice.'

Q. Dr. Schuster, one of the questions that I have raised before, and Mr. Bell raises it in his testimony today, is how do we reach those who are not in school and who may be more likely to use drugs?

A new NIDA initiative, the Metropolitan Area Surveys Study, is expected to provide critical data that will supplement information obtained from the Household Survey. The Metropolitan Area Surveys Study is a large-scale, 3-year effort to collect drug abuse data from so-called hidden populations, that is, from those who are excluded from other major surveys, such as the homeless and transient, institutionalized, high school dropouts, and criminal offenders. These subgroup populations are generally excluded from NIDA's two major prevalence measures of drug abuse, the National Household Survey on Drug Abuse and the High School Senior Survey, either because they do not reside in households, or have dropped out of school, or for other reasons have become difficult to reach. Data that are available are generally anecdotal or based on small qualitative research methods (such as participant observation, field station research, and unstructured interviews). These data suggest that hidden populations are highly susceptible to abusing

drugs and experiencing adverse effects from doing so. The initial site for the study is the Washington, D.C., metropolitan area. Results from this effort are expected to be available in 1992. The methods developed during the course of the project are anticipated to have applicability for further, ongoing studies of drug abuse among hidden populations in other metropolitan areas.

Because adolescents who drop out of high school are more at risk for using drugs, NIDA supports a broad range of prevention intervention research that will reach as many vulnerable youth as possible. We know from our etiologic studies that many paths and processes lead to drug using behaviors; therefore, any intervention program must consist of several strategies. The comprehensive, community-based approach to drug abuse prevention is designed to involve as many important segments of a community as possible including schools, families, businesses, churches, policy, and political and social agencies. It is only through a comprehensive program of this nature that one can assure that as many young people as possible are reached. Furthermore, such a prevention program must include elements that address those antecedents who live in social situations which make them more vulnerable to the use of drugs. Programs that provide parenting skills to young parents and to parents who at one time may themselves have been drug abusers, and, that provide age-appropriate interpersonal, intrapersonal, and instrumental skills (academic performance, physical activities) to youngsters from pre-school through young adulthood will have the greatest impact not only on drug abuse but also other negative social behaviors such as teenage pregnancy and delinquency. NIDA supports research to indicate that these intervention components are effective in influencing the targeted skills and behaviors (such as parenting skills, academic performance, anti-social behaviors), and although still fairly new (many of these studies are only in their third or fourth year), these studies are beginning to show statistically significant differences in the use of tobacco, alcohol and marijuana in youngsters in experimental compared to control conditions.

It is fair to say that all drug abuse treatment programs experience real difficulty in reaching youthful drug abusers and that the problem is compounded when the youngsters are no longer attending school. Indeed, one of the problems we face is that youngsters who are involved in drugs are more likely to drop out of school.

We know from a study conducted at NIDA's Addiction Research Center that, as a group, youngsters are far less likely to refer themselves voluntarily for drug abuse treatment than are their adult counterparts. Consequently, it becomes essential that we develop and test strategies designed to identify and reach these youngsters before they bring further difficulty on themselves and their communities. To accomplish that, we will need to work with

those community agencies and organizations and those service providers who are most likely to be in contact with youngsters in trouble. In particular, we need to conduct outreach in association with health care, social service and criminal justice agencies--all of which are likely to come in contact with youngsters involved with illicit drugs. These young people are prone to be multi-problem youth and will, therefore, come to the attention of such health care agencies as hospital emergency rooms, sexually transmitted disease clinics, public health agencies, programs for pregnant adolescents, etc. They are likely to be seen in runaway houses, child abuse/neglect programs, foster care programs, etc., in terms of social service agencies and may be seen in juvenile detention and juvenile probation programs in terms of the criminal justice system. In those systems youngsters can be expected to be more accepting of drug abuse services both because of a likely increased awareness of their own vulnerability and because these systems can be engaged as allies in identifying and referring youngsters to needed drug abuse treatment services.

NIDA is, in fact, working with NIMH in developing a monograph describing models for working with homeless and runaway youth encountered in the community. NIDA also has studies planned to expand its current program of research into the efficacy of strategies for reaching runaway and homeless youth and directing those youngsters to treatment and educating them to protect themselves against HIV infection. In addition, NIDA will be expanding its efforts to work with delinquent youth in evaluating strategies for directing those youngsters into appropriate treatment forms. Both delinquent and runaway youth have been found overwhelmingly to be involved in illicit drug use.

Finally, a critical player in the strategy for reaching children who are not in school and therefore may be more likely to use drugs is ADAMHA's Office for Substance Abuse Prevention (OSAP). Many of those children and adolescents also meet these other criteria to which OSAP targets special help: they are abused or neglected; they have committed violent or delinquent acts; they have suffered from mental health problems and perhaps attempted suicide; they are pregnant; they are latchkey children; they are children of substance abusers; and they are economically disadvantaged. OSAP has funded and continues to fund various community level service demonstration projects designed to focus on these high-risk individuals. As a part of that process and to provide technical assistance for private sector initiatives, OSAP has developed partnerships with parent groups, policy makers, health practitioners, law enforcement officials, volunteers and others.

SENATOR DURENBERGER'S QUESTIONS

Q. Much research is currently being done on the causes of drug and alcohol abuse. From this information what have we found out about the available treatment methods that can act in a preventive way to get at the underlying aspects of substance abuse?

A. Much of our knowledge in this area has to do with physiological and behavioral aspects (dependence), underlying psychopathology, and coping deficits which result in relapse.

With regard to dependence, we have detoxification regimens which withdraw clients in a humane way as a first step in treatment, and maintenance regimens which block craving and enable clients to get on with the business of rehabilitation. A major problem with regard to dependence is 'conditioned craving' which is sometimes triggered by the sight of particular objects, being around particular friends, or being in surroundings where drugs were used. This conditioned craving is thought to contribute to relapse in some individuals. Work on extinction (eradication of conditioned craving) is now being done by Dr. Charles O'Brien at the University of Pennsylvania to reverse the conditioning effects of drug use. This work should lead to new treatments which eradicate some of the underlying causes of relapse.

Psychopathology, notably depression, antisocial personality disorder contribute to drug use in different ways. Depression makes coping with stresses of everyday life more difficult, and some drug misuse may represent dysfunctional coping efforts (including attempts at self-medication) among those with depression or anxiety disorders. Antisocial personality disorder is characterized by poor impulse control, a tendency not to accept responsibility for one's own actions, and rootlessness, and tends to be expressed through lifestyles which include predilections toward criminal involvement, drug and alcohol use, and unstable living patterns. Depression and anxiety disorders are usually treated by medication and/or psychotherapy and research by Dr. George Woody at the University of Pennsylvania provides evidence that psychotherapy can help the severely depressed opiate abuser in reducing or ceasing drug use. Other research under way, notably that of Dr. Bruce Rounsaville at Yale University, systematically tests the use of antidepressant medications in combination with psychotherapy in the treatment of cocaine dependence. Antisocial personality disorder tends to be a difficult problem since it involves personality organization which develops over a lifetime. For this disorder, behavior strategies such as contingency management and confrontational, resocialization-oriented treatments such as residential therapeutic communities appear to be more appropriate interventions.

Relapse prevention is generally divided into two types of strategies to forestall return to drug use. External strategies,

often termed 'aftercare,' attempt to prevent relapse by providing social support and monitoring to maintain the gains made in treatment. Aftercare provisions may include self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, enrollment in outpatient counseling programs, pharmacological agents such as narcotic antagonists, regular contacts by aftercare workers, and urine testing. A key principle outlined by Drs. Frank Tims and Carl Leukefeld in recent work is that of systematic follow-up of clients at critical points after treatment, i.e., at one week, one month, three months, and one year. Internal strategies include such approaches as 'cognitive-behavioral' interventions to build relapse prevention skills and improve coping. These may focus on learning to recognize the kinds of situations which may bring on urges and social pressures to use drugs, and how to either avoid these situations or respond to them in ways which do not lead to resumption of drug use. Learning how to deal with stress, to handle interpersonal situations in a healthy, productive way, to tolerate or relieve boredom, and to understand that there are more and better alternatives to the handling the problems of life than returning to drug use, are key features of a method called 'relapse prevention training,' which is widely used in treating drug abusers.

In addition to these activities, NIDA supports efforts through its Prevention Research Branch that, among other things, address the challenge of preventing first-time drug use. The Branch: 1) administers a national program of etiological research to specify factors that are associated with vulnerability to drug abuse and dependency practices and that are associated with initiation and continued abuse of drugs including: (a) genetic and other biological mechanisms; (b) social, parenting, and psychological influences; (c) environmental and social contextual influences; and, (d) human development studies, examining the relationship between drug abuse as an antecedent to developmental problems and as a result of developmental problems; (2) administers a national program of prevention and early intervention research in drug abuse, including: (a) effectiveness of current and innovative prevention models; (b) strategies for community drug abuse prevention efforts; (c) impact of changes in law on the incidence and prevalence of drug use; (d) institutional and community responses to the drug abuse problems; (e) group processes associated with behavior and attitudinal change related to drug use; (3) supports research training to increase the quantity and quality of prevention research investigators; (4) provides consultation to researchers interested in developing prevention research projects, and monitors related projects; (5) sponsors, develops, and/or participates in scientific conferences, meetings, and symposia; (6) prepares technical/scientific reports, summaries, and other materials concerned with prevention aspects of drug

abuse; and, (7) pro-actively collaborates with other federal agencies in the national demand reduction program.

Q. President Bush's recent proposal to fight the war on drugs included a new effort to increase user accountability. How do you think this new focus on users will affect an addicts efforts to get treatment. Do you think that such a change will cause a negative stigma on treatment and rehabilitation?

A. It is important to clarify that the term "user accountability" applies not only to addicts but also to casual users. A key element of the National Drug Control Strategy is to hold all users accountable for their actions. Increased social sanctions; community, school, and workplace based prevention programs; and media campaigns are already working as reflected in statistics that show the prevalence of drug abuse declining. In the short run, the likely effect of "user accountability" is to increase the demand for treatment. However, over the long haul the strategy has the potential for preventing drug experimenters from progressing to the type of chronic drug use that requires treatment and the strategy is likely to prevent users from initiating "new users" into drug experimentation.

User accountability will stigmatize drug use and the drug user, but it is unlikely to stigmatize treatment itself. We should be cautious, however, that user accountability does not overly reinforce a common perception of the drug abuser as merely a criminal. If this were to occur, national opinion would insist that the penal system is the only appropriate tool for dealing with the chronic drug abuser rather than the current national strategy that recognizes the value of treatment in controlling the demand for drugs.

The CHAIRMAN. Of the 300 residents, what percent of those have AIDS or have tested positive?

Reverend WILLIAMS. It is increasing now. One of the things that limits me from giving you an accurate description of that is that we send our people out for medical attention usually to local hospitals, and the law then prohibits them from giving that information back to us. So that the only way we can make a determination is if the client reveals it himself or herself. And of that, we have about 22 percent who have come back on their own volition and indicated that they have tested positive.

The CHAIRMAN. What did you pattern your treatment model after?

Reverend WILLIAMS. Well, the concept really stems from the vision of Mr. James Allen who, back in 1957, began to do this work. He got involved in it because a drug addict came into a local church and said that he had heard that people had been passing out tracts that God loves them, and he wanted to know whether God loves drug addicts as well. And after a series of meetings, he started this residential program that has been in continual existence since that time.

We believe that we can help the addict get off the drugs without the use or substitution of another drug by providing both inspiration and incentive and trying to help them in development of positive actions and replacing old destructive ways and again trying to give them support services in the community in which they live.

The CHAIRMAN. Dr. Des Jarlais, what do you see in terms of the flow lines, just say in New York, in terms of the drugs and the HIV-positive?

Dr. DES JARLAIS. Well, currently more than half of the new AIDS cases in New York are related to drug use, so that the drug use as a risk factor has superseded male homosexual activity.

Right now, because we have been doing some successful AIDS prevention efforts in our outreach efforts, we do have people going out and doing face-to-face AIDS prevention, the situation seems to have stabilized at approximately 50 percent of the 200,000 IV-drug users in the city with HIV. That seems to be relatively stable and not going up very highly. Of course, it is not the same 200,000 people from year to year. Many of the people who leave drug use, some are dying, some have had a long history of drug use and are HIV-infected. The new people starting to inject drugs are almost all free of the virus when they start. So we would estimate there may be 5,000 to 10,000 new HIV infections among people injecting drugs in New York right now.

Among people smoking crack, we do not have very good data yet, but it is clear the virus is spreading moderately rapidly among that group. Clearly, crack is a new problem; it is maybe 3, 4 years old in the city. The biggest worry is syphilis as an indicator of unsafe sexual activity and also as a factor that may make it easier to transmit HIV; that the rate of syphilis, particularly among young heterosexuals smoking crack, has more than doubled in the city over the last couple of years. So that we are seeing a syphilis epidemic that is associated with crack use, and we know that an HIV epidemic is right behind that.

The CHAIRMAN. Thank you very much. I appreciate your testimony. It is certainly a challenging testimony for all of us, but it has been very helpful to us as well.

The committee stands in recess.

[Whereupon, at 11:45 a.m., the committee was adjourned.]

23-163 (216)